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CHAPTER III
SURGERY: INTEGUMENTARY SYSTEM
CPT CODES 10000-19999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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TABLE OF CONTENTS

Chapter III
Surgery: Integumentary System
CPT Codes 10000 - 19999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 10000-19999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should 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 should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. 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.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. *In general* E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contain*s many, but not all, possible* edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same

day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Local anesthesia including local infiltration, regional blocks, mild sedation, and all other anesthesia services except moderate conscious sedation reportable as CPT codes 99143-99145 are not separately reportable by a physician performing a medical or surgical procedure.

Billing for "anesthesia" services rendered by a nurse or other office personnel (unless the nurse is an independent certified nurse anesthetist, CRNA, etc.) is inappropriate as these services are “incident to” the physician’s services.

It is a misuse of therapeutic injection or aspiration CPT codes to report administration of local anesthesia for a procedure. For example, it is a misuse of CPT codes 10160 (puncture aspiration), 20500-20501 (injection of sinus tract), 20526-20553 (injection of carpal tunnel, tendon sheath, ligament, trigger points, etc.), 20600-20610 (arthrocentesis) to report administration of local anesthetic for another procedure.

CPT codes 64450 (injection, anesthetic agent; other peripheral nerve or branch) and 64455 (injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton’s neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily hospital adjustment/management of the catheter, dosage, etc., (CPT code 01996). This service may be reported by the anesthesia practitioner. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days by the managing physician.

D. Incision and Drainage

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, abscesses, seromas or fluid collections.

If it is necessary to incise and/or drain a lesion as part of another procedure or in order to gain access to an area for another procedure, the incision and/or drainage is not separately reportable if performed at the same patient encounter.

For example, a physician excising pilonidal cysts and/or sinuses (CPT codes 11770-11772) may incise and drain one or more of the cysts. It is inappropriate to report CPT codes 10080 or 10081 separately for the incision and drainage of the pilonidal cyst(s).

HCPCS/CPT codes for incision and drainage should not be reported separately with other procedures such as excision, repair, destruction, removal, etc., when performed at the same anatomic site at the same patient encounter.

HCPCS/CPT codes describing complications of a procedure may or may not be separately reportable at the same patient encounter as the procedure causing the complication. (See Chapter I, Section C.13)

CPT code 10180 (incision and drainage, complex, postoperative wound infection) would never be reportable for the same patient encounter as the procedure causing the postoperative infection. It may be separately reportable with a subsequent procedure depending upon the circumstances. If it is performed to gain access to an anatomic region for another procedure, CPT code 10180 is not separately reportable. However, if the procedure described by CPT code 10180 is performed at an anatomic site unrelated to another procedure, it may be reported separately with the procedure.

E. Lesion Removal

HCPCS/CPT codes define different types of removal codes such as destruction (e.g., laser, freezing), debridement, paring/cutting, shaving, or excision. Only one removal HCPCS/CPT code may be reported for a lesion. If multiple lesions are included in a single removal procedure (e.g., single excision of skin containing three nevi), only one removal HCPCS/CPT code may be reported for the procedure. If a removal procedure is begun by one method but is converted to another method to complete the procedure, only the HCPCS/CPT code describing the completed procedure may be reported. If multiple lesions are removed separately, it may be appropriate depending upon the code descriptors for the procedures to report multiple HCPCS/CPT codes

utilizing anatomic modifiers or modifier 59 to indicate different sites or lesions. The medical record must document the appropriateness of reporting multiple HCPCS/CPT codes with these modifiers.

The HCPCS/CPT codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter. CPT codes 11100-11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately. CPT codes 11100-11101 may be separately reportable with lesion removal HCPCS/CPT codes if the biopsy is performed on a different lesion than the removal procedure.

Removed tissue is often submitted for surgical pathology evaluation generally reported with CPT codes 88300-88309. If multiple lesions are submitted for pathological examination as a single specimen, only one CPT code may be reported for examination of all the lesions even if each lesion is processed separately. However, if it is medically reasonable and necessary to submit multiple lesions separately identifying the precise location of each lesion, a separate surgical pathology CPT code may be reported for each lesion.

If a physician reviews pathology slides from previously removed lesion(s) in association with an evaluation and management (E&M) service to determine whether additional surgery is required, the review of the pathology slides is included in the E&M service. The physician should not report CPT codes 88321-88325 (surgical pathology consultation) in addition to the E&M code.

Lesion removal may require closure (simple, intermediate, or complex), adjacent tissue transfer, or grafts. If the lesion removal requires dressings, strip closure, or simple closure, these services are not separately reportable. Thus, CPT codes 12001-12021 (simple repairs) are integral to the lesion removal codes. Intermediate or complex repairs, adjacent tissue transfer, and grafts may be separately reportable if medically reasonable and necessary. However, excision of benign lesions with excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440) includes simple, intermediate, or complex repairs which should not be reported separately.

If lesion removal, incision, or repair requires debridement of non-viable tissue surrounding a lesion, incision, or injury in order to complete the procedure, the debridement is not separately reportable.

F. Mohs Micrographic Surgery

Mohs micrographic surgery (CPT codes 17311-17315) is performed to remove complex or ill-defined cutaneous malignancy. A single physician performs both the surgery and pathologic examination of the specimen(s). The Mohs micrographic surgery CPT codes include skin biopsy and excision services (CPT codes 11100-11101, 11600-11646, and 17260-17286) and pathology services (88300-88309, 88329-88332). Reporting these latter codes in addition to the Mohs micrographic surgery CPT codes is inappropriate. However, if a suspected skin cancer is biopsied for pathologic diagnosis prior to proceeding to Mohs micrographic surgery, the biopsy (*e.g.,* CPT codes 11100-11101) and frozen section pathology (CPT code 88331) may be reported separately utilizing modifier 59 or 58 to distinguish the diagnostic biopsy from the definitive Mohs surgery. Although the *CPT Manual* indicates that modifier 59 should be utilized, it is also acceptable to utilize modifier 58 to indicate that the diagnostic skin biopsy and Mohs micrographic surgery were staged or planned procedures. Repairs, grafts, and flaps are separately reportable with the Mohs micrographic surgery CPT codes.

G. Intralesional Injections

CPT codes 11900-11901 describe intralesional injections of non-chemotherapeutic agents. CPT codes 96405-96406 describe intralesional injections of chemotherapeutic agents. Two intralesional injection codes should not be reported together unless separate lesions are injected with different agents in which case modifier 59 may be utilized. It is a misuse of CPT codes 11900, 11901, 96405, or 96406 to report injection of local anesthetic prior to another procedure on the lesion(s). Some of the procedures with which CPT codes 11900, 11901, 96405, and 96406 are not separately reportable if the intralesional injection is a local anesthetic include:

11200 - 11201	(Removal of skin tags)
11300 - 11313	(Shaving of lesions)
11400 - 11471	(Excision of lesions)
11600 - 11646	(Excision of lesions)
12001 - 12018	(Repair - simple)
12020 - 12021	(Treatment of wound dehiscence)
12031 - 12057	(Repair - intermediate)
13100 – 13160	(Repair - complex)
11719 – 11762	(Trimming, debridement and excision of nails)
11765	(Wedge excision)

11770 – 11772 (Excision of pilonidal cysts)

This list in not an exhaustive listing of the procedures since the administration of local anesthesia by the physician performing a procedure is not separately reportable for any procedure.

H. Repair and Tissue Transfer

The *CPT Manual* classifies repairs (closure) (CPT codes 12001-13160) as simple, intermediate, or complex. If closure cannot be completed by one of these procedures, adjacent tissue transfer or rearrangement (CPT codes 14000-14350) may be utilized. Adjacent tissue transfer or rearrangement procedures include excision (CPT codes 11400-11646) and repair (12001-13160). Thus, CPT codes 11400-11646 and 12001-13160 should not be reported separately with CPT codes 14000-14350 for the same lesion or injury. Additionally debridement necessary to perform a tissue transfer procedure is included in the procedure. It is inappropriate to report debridement (e.g., CPT codes 11000, 11042-11047, 97597, 97598) with adjacent tissue transfer (e.g., CPT codes 14000-14350) for the same lesion/injury.

Skin grafting in conjunction with a repair or adjacent tissue transfer is separately reportable if the grafting is *not* included in the code descriptor of the adjacent tissue transfer code.

Adjacent tissue transfer codes should not be reported with the closure of a traumatic wound if the laceration is coincidentally approximated using a tissue transfer type closure (e.g., Z-plasty, W-plasty). The closure should be reported with repair codes. However, if the surgeon develops a specific tissue transfer to close a traumatic wound, a tissue transfer code may be reported.

Procurement of cultures or tissue samples during a closure is included in the repair or adjacent tissue transfer codes and are not separately reportable.

I. Grafts and Flaps

CPT codes describing skin grafts and skin substitutes are classified by size, location of recipient area defect, and type of graft or skin substitute. For most combinations of location and type of graft/skin substitute, there are two or three CPT codes including a primary code and one or two add-on codes. The primary code describes one size of graft/skin substitute and

should not be reported with more than one unit of service. Larger size grafts or skin substitutes are reported with add-on codes.

The primary graft/skin substitute codes (e.g., 15100, 15120, 15200, 15220) are mutually exclusive since only one type of graft/skin substitute can be utilized at an anatomic site. If multiple sites require different types of grafts/skin substitutes, the different graft/skin substitute CPT codes should be reported with anatomic modifiers or modifier 59 to indicate the different sites.

Simple debridement of a skin wound (CPT codes 11000, 11042-11045, 97597, 97598) prior to a graft/skin substitute is included in the skin graft/skin substitute procedure (CPT codes 15050-15431) and should not be reported separately. If the recipient site requires excision of open wounds, burn eschar, or scar or incisional release of scar contracture, CPT codes 15002-15005 may be separately reportable for certain types of skin grafts/skin substitutes.

1. A *CPT Manual* instruction following CPT code 67911 (Correction of lid retraction) states that autogenous graft CPT codes (20920, 20922, or 20926) may be reported separately. All other services necessary to complete the procedure are included.

J. Breast (Incision, Excision, Introduction, Repair and Reconstruction)

1. Since a mastectomy (CPT codes 19300-19307) describes removal of breast tissue including all lesions within the breast tissue, breast excision codes (19110-19126) generally are not separately reportable unless performed at a site unrelated to the mastectomy. However, if the breast excision procedure precedes the mastectomy for the purpose of obtaining tissue for pathologic examination which determines the need for the mastectomy, the breast excision and mastectomy codes are separately reportable. (Modifier 58 may be utilized to indicate that the procedures were staged.) If a diagnosis was established preoperatively, an excision procedure for the purpose of obtaining additional pathologic material is not separately reportable.

Similarly, diagnostic biopsies (e.g., fine needle aspiration, core, incisional) to procure tissue for diagnostic purposes to determine whether an excision or mastectomy is necessary at the same patient encounter may be reported with modifier 58 appended to the excision or mastectomy code. However, biopsies (e.g.,

fine needle aspiration, core, incisional) are not separately reportable if a preoperative diagnosis exists.

2. The breast procedure codes include incision and closure. Some codes describe mastectomy procedures with lymphadenectomy and/or removal of muscle tissue. The latter procedures are not separately reportable. Except for sentinel lymph node biopsies, ipsilateral lymph node excisions are not separately reportable. Contralateral lymph node excisions may be separately reportable with appropriate modifiers (i.e., LT, RT).

3. Sentinel lymph node biopsy is separately reportable when performed prior to a localized excision of breast or a mastectomy without lymphadenectomy. However, sentinel lymph node biopsy is not separately reportable with a mastectomy procedure that includes lymphadenectomy in the anatomic area of the sentinel lymph node biopsy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38510), internal mammary (CPT code 38530). (CPT code 38740(axillary lymphadenectomy; superficial) should not be reported for a sentinel lymph node biopsy. Sentinel lymph node biopsy of superficial axillary lymph node(s) is correctly reported as CPT code 38500 (biopsy or excision of lymph node(s), superficial) which includes the removal of one or more discretely identified superficial lymph nodes. By contrast a superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue.)

4. Breast reconstruction codes that include the insertion of a prosthetic implant should not be reported with codes that separately describe the insertion of a breast prosthesis.

5. CPT codes for breast procedures generally describe unilateral procedures.

6. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with *mammographic* guidance (e.g., *19281,19282*), the physician should not separately report a post procedure mammography code (e.g., 77051, 77052, 77055-77057, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging *by the defined modality* required to perform the procedure.

K. 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 MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The unit of service for fine needle aspiration (CPT codes 10021 and 10022) is the separately identifiable lesion. If a physician performs multiple "passes" into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion.

4. The CMS Internet Only Manual (Publication 100-04 Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

L. General Policy Statements

1. In this Manual 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 Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet Only Manual* (*IOM*) instructions.

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

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

5. CPT codes 15851 and 15852 describe suture removal and dressing change respectively under anesthesia other than local anesthesia. These codes should not be reported when a patient requires anesthesia for a related procedure (e.g., return to the operating room for treatment of complications where an incision is reopened necessitating removal of sutures and redressing). Additionally, CPT code 15852 should not be reported with a primary procedure.

6. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure. (See Section C. Anesthesia)

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62310-62319, 64400-64484, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

7. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

8. Closure/repair of a surgical incision is included in the global surgical package except as noted below. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes

(CPT codes 12001-13153) should not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

9. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

10. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

11. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at

the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

12. The NCCI edits with column one CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesions) each with column two CPT codes 11720-11721 (Nail debridement by any method) are often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 11720 or 11721 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed for lesions anatomically separate from one another or if the two procedures are performed at separate patient encounters. CPT codes 11055-11057 must not be used to report removal of hyperkeratotic skin adjacent to nails requiring debridement.

13. The NCCI edits with column one CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) each with column two CPT code 11100 (Biopsy of single skin lesion) are often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 11100 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed on separate lesions or at separate patient encounters. Refer to the *CPT Manual* instructions preceding CPT code 11100 for additional clarification about the CPT codes 11100-11101.

14. The NCCI edit with column one CPT code 11719 (Trimming of nondystrophic nails) and column two CPT code 11720 (Nail debridement by any method, one to five nails) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 11720 of this NCCI edit is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters.

15. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

16. Most NCCI 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 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.

17. 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.