

NCCI Version 14.3 – Revisions/Additions/Deletions – Chapter 9

Added Language

Section B. Evaluation and Management Services

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 does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have 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.

Revised Language

Section D. Interventional/Invasive Diagnostic Imaging

If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT codes 36000, 36406, 36410) and contrast administration (e.g., CPT codes 90760-90775) are integral to the procedure and are not separately reportable.

Many services utilizing contrast are composed of a procedural component (CPT codes outside the 70000 section) and a radiologic supervision and interpretation component (CPT code in the 70000 section). If a single physician performs both components of the service, the physician may report both codes. However, if different physicians perform the different components, each physician reports the CPT code corresponding to that component.

Added Language

Section D. Interventional/Invasive Diagnostic Imaging

Many interventional procedures require contrast injections for localization and/or guidance. Unless there are CPT instructions directing the physician to report specific CPT codes for the localization or guidance, the localization or guidance is integral to the interventional procedure and is not separately reportable.

Revised Language

Section D. Interventional/Invasive Diagnostic Imaging

The individual CPT codes in the 70000 section identify which injection or administration code, if any, is appropriate for a given procedure. In the absence of a parenthetical CPT note, the injection or administration service is integral to the procedure and is not separately reportable. If an intravenous line is inserted (e.g., CPT code 36000) for access in the event of a problem with the procedure or for administration of contrast, it is integral to the procedure and is not separately reportable. CPT code 36005 describes the injection procedure for contrast venography of an extremity and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000). CPT code 36005 should not be reported for injections for arteriography or venography of sites other than an extremity.

Added Language

Section E. Nuclear Medicine

5. CPT code 78465 (myocardial perfusion imaging; tomographic (SPECT) . . . with or without quantification) includes calculation of the heart-lung ratio if obtained. CPT code 78580 (pulmonary perfusion imaging, particulate) should not be reported for calculation of the heart-lung ratio during the processing of a SPECT myocardial perfusion procedure.

Added Language

Section G. Medically Unlikely Edits (MUEs)

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

Revised Language

H. General Policy Statements

6. Ultrasound guidance and diagnostic ultrasound (echography) procedures may be reported separately only if each service is distinct and separate. If a diagnostic ultrasound study identifies a previously unknown abnormality that requires a therapeutic procedure with ultrasound guidance at the same patient encounter, both the diagnostic ultrasound and ultrasound guidance procedure codes may be reported separately. However, a previously unknown abnormality identified during ultrasound guidance for a procedure should not be reported separately as a diagnostic ultrasound procedure.

Added Language

H. General Policy Statements

20. 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.

NCCI Version 14.3 – Revisions/Additions/Deletions – Chapter 5

Revised Language

Section B. Evaluation and Management Services

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 does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have 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.

Revised Language

D. Cardiovascular System

16. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M).

Note: Prior instruction rescinded! If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures.

Added Language

D. Cardiovascular System

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

Added Language

D. Cardiovascular System

25. CPT codes 33203, 33265, and 33266 describe surgical endoscopic procedures (CPT code 33203 – insertion of epicardial electrodes; CPT codes 33265, 33266 – operative tissue ablation). CPT codes 32603 and 32604 describe diagnostic thoracoscopy of the pericardial sac. Since surgical endoscopy includes diagnostic endoscopy, CPT codes 32603/32604 should not be reported separately with CPT codes 33203/33265/33266 for the same patient encounter.

Revised Language and Relocated from the Respiratory Section

G. General Policy Statements

11. 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.

Note:

This document is a quick reference that summarizes only a portion of changes to the NCCI Manual. Everyone is strongly encouraged to review the NCCI manual in its entirety. The NCCI Manual may be downloaded at:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp