CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 20000-29999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Providers/suppliers shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A provider/supplier shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A provider/supplier shall not separately report these services simply because HCPCS/CPT codes exist for them.

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

B. Evaluation & Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting Evaluation & 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 MAC. 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 National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to the NCCI program. 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 days 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 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 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. The NCCI program does not contain edits based on this rule because Medicare Administrative Contractors (MACs) 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 shall 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/supplier 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 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"), unless related to a complication of surgery.

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 shall **not** 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 provider/supplier 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 "XXX" 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 "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 provider/supplier shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the provider/supplier shall 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 (e.g., CPT codes 96360-96379) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare 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.

Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) shall not be reported for the administration of local anesthesia to perform another procedure. The NCCI program contains many edits based on this principle. If a procedure and a separate and distinct injection service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI-associated modifier if appropriate.

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) (eg, Morton's neuroma)) shall 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.

D. Biopsy

For more information regarding biopsies, see Chapter I, Section A, Introduction.

E. Arthroscopy

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

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

3. If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code shall be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.

4. With 3 exceptions (which are described in Chapter IV, Section E (Arthroscopy), Subsection 7), an NCCI PTP edit code pair consisting of 2 codes describing 2 shoulder arthroscopy procedures shall not be bypassed with an NCCI PTP-associated modifier when the 2 procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI PTP-associated modifier only if the 2 procedures are performed on contralateral shoulders.

5. With the exception of the knee and shoulder, arthroscopic debridement shall not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter. For knee arthroscopic debridement see the following subsection. For shoulder arthroscopic debridement, see Subsection 7 below.

6. CPT codes 29874 (Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) and 29877 (Arthroscopy, knee, surgical; for debridement/shaving of articular cartilage (chondroplasty)) **shall** not be reported with other knee arthroscopy codes (29866-29889). With 2 exceptions, HCPCS code G0289 (Arthroscopy, knee, surgical; for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee)) may be reported with other knee arthroscopy codes. Since CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty) same or separate compartment(s), when performed) and 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty) same or separate compartment(s), when performed) include debridement/shaving of articular cartilage of any compartment, HCPCS code G0289 may be reported with CPT codes 29880 or 29881 only if reported for removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 shall not be reported for removal of a loose body or foreign body or debridement/shaving of articular cartilage from the same compartment as another knee arthroscopic procedure.

7. Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With 3 exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)), 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair), and 29828 (Arthroscopy, shoulder, surgical; biceps tenodesis) may be reported separately with CPT code 29823 if the

extensive debridement is performed in a different area of the same shoulder.

8. Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (Limited synovectomy, "separate procedure") or 29876 (Major synovectomy of two or three compartments). A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 shall not be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in 2 compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 shall not be reported for a major synovectomy with CPT code 29880 (Knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee, since knee arthroscopic procedures other than synovectomy are performed in 2 of the 3 knee compartments.

F. Spine (Vertebral Column)

1. Exploration of the surgical field is a standard surgical practice. Providers/suppliers shall not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 shall not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59 or XS.

2. Some procedures (e.g., spine) frequently use intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941, and G0453) shall not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second provider/supplier. The physician performing an operative procedure shall not bill other 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package. (CPT code 92585 was deleted January 1, 2021.)

3. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) and other spinal procedures include manipulation of the spine as an integral component of the procedures. CPT code 22505 (Manipulation of spine requiring anesthesia, any region) shall not be reported separately.

4. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes, there is an Add-on Code (AOC) for reporting the same procedure at each additional level without specification of the spinal region for the AOC. When multiple procedures from one of these families of codes are

performed at contiguous vertebral levels, a provider/supplier shall report only one primary code within the family of codes for one level and shall report additional contiguous levels using the AOC(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed through separate skin incisions at multiple vertebral levels that are not contiguous and in different regions of the spine, the provider/supplier may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an AOC describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code (i.e., the one for the first procedure) may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4 through separate skin incisions, the provider/supplier may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the provider/supplier may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

5. CPT codes 22600-22614 describe arthrodesis by posterior or posterolateral technique and lateral transverse technique when performed. CPT codes 22630-22632 describe arthrodesis by posterior interbody technique. CPT codes 22633-22634 describe arthrodesis by combined posterior or posterolateral technique with posterior interbody technique. These codes are reported per level or interspace. CPT code 22614 is an AOC that may be reported with primary CPT codes 22600, 22610, 22612, 22630, or 22633. CPT code 22632 is an AOC that may be reported with primary CPT codes 22612, 22630, or 22633. CPT code 22634 is an AOC that may be reported with primary CPT code 22633.

If a physician performs arthrodesis across multiple interspaces using the same technique in the same spinal region, the provider/supplier shall report a primary code for the first interspace and an AOC for each additional interspace. If the interspaces span 2 different spinal regions through the same skin incision, the provider/supplier shall report a primary code for the first interspace and an AOC for each additional interspace. If the interspaces span 2 different spinal regions through different skin incisions, the provider/supplier may report a primary code for the first interspace through each skin incision and an AOC for each additional interspace through the same skin incision.

If a physician performs arthrodesis across multiple contiguous interspaces through the same skin incision using different techniques, the provider/supplier shall report one primary code for the

first interspace and AOC for each additional interspace.

If a physician performs arthrodesis across multiple non-contiguous interspaces through the same skin incision using different techniques, the provider/supplier shall report one primary code for the first interspace and AOCs for each additional interspace.

If a physician performs arthrodesis across multiple non-contiguous interspaces through different skin incisions using different techniques, the provider/supplier may report one primary code for the first interspace through each skin incision and AOCs for each additional interspace through the same skin incision.

6. Fluoroscopy reported as CPT code 76000 shall not be reported with spinal procedures, unless there is a specific "CPT Manual" instruction indicating that it is separately reportable. For some spinal procedures, there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure. (CPT code 76001 was deleted January 1, 2019.)

7. CPT code 38220 describes diagnostic bone marrow aspiration(s). It shall not be reported separately with musculoskeletal procedures (e.g., spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, laminectomy, spinal decompression, vertebral corpectomy), for bone marrow aspiration for platelet rich stem cell injection, or other therapeutic musculoskeletal applications.

8. CPT codes 38230 (Bone marrow harvesting for transplantation; allogeneic) and 38232 (Bone marrow harvesting for transplantation; autologous) shall not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code for procurement of bone marrow aspirate. CPT codes 38230 and 38232 are used to report the procurement of bone marrow for future bone marrow transplantation.

9. CMS payment policy does not allow separate payment for CPT codes 63042 (Laminotomy...; lumbar) or 63047 (Laminectomy...; lumbar) with CPT codes 22630 or 22633 (Arthrodesis; lumbar) when performed at the same interspace. If the 2 procedures are performed at different interspaces, the 2 codes of an edit pair may be reported with modifier 59 or XS.

10. Only one anterior or posterior instrumentation CPT code (e.g., CPT codes 22840-22847) may be reported through a single skin incision.

11. CPT codes 22853 and 22854 describe insertion of interbody biomechanical device(s) into intervertebral disc space(s). Integral anterior instrumentation to anchor the device to the intervertebral disc space when performed is not separately reportable. It is a misuse of anterior instrumentation CPT codes (e.g., 22845-22847) to report this integral anterior

instrumentation. However, additional anterior instrumentation (i.e., plate, rod) unrelated to anchoring the device may be reported separately appending an NCCI-associated modifier such as modifier 59 or XU.

12. The PTP edit with Column One CPT code 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar) and Column Two CPT code 63056 (Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)) consists of 2 CPT codes with code descriptors representing different surgeries. The edit indicates that the 2 procedures shall not be reported together at the same anatomic site (spinal level) at the same patient encounter. A provider/supplier shall not use modifiers 59 or -X{ES} to bypass this edit unless the 2 procedures are performed at separate anatomic sites (i.e., different spinal levels) or separate patient encounters on the same date of service.

G. Fractures, Dislocations, and Casting/Splinting/Strapping

1. The application of external immobilization devices (casts, splints, strapping) at the time of a procedure includes the subsequent removal of the device when performed by the same entity (e.g., physician, practice, group, employees, etc.) Providers/suppliers shall not report removal or repair CPT codes 29700-29750 for those services. These removal or repair CPT codes may only be reported if the initial application of the cast, splint, or strapping was performed by a different entity.

2. Casting/splinting/strapping CPT codes shall not be reported for application of a dressing after a therapeutic procedure.

3. Casting/splinting/strapping shall not be reported separately if a service from the Musculoskeletal System section of CPT (20100-28899 and 29800-29999) is also performed for the same anatomic area.

4. Debridement including removal of foreign material at the site of an open fracture or open dislocation may be reported with CPT codes 11010-11012. Since these codes would be reported with a CPT code for treatment of the open fracture or dislocation, a casting/splinting/strapping code shall not be reported separately.

5. If an ankle fracture or dislocation repair is stabilized with a strapping, the ankle fracture or dislocation repair CPT code shall not be reported with a strapping code such as CPT code 29581 (Application of multi-layer compression system; leg (below knee), including ankle and foot) even if the strapping simultaneously treats another problem such as edema or a venous stasis ulcer. Fracture and dislocation CPT codes include the initial casting, strapping, or splinting.

6. CPT codes for closed, percutaneous, or open treatment of fractures or dislocations include the application of casts, splints, or strapping. CPT codes for casting/splinting/strapping shall not be reported separately.

7. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the provider/supplier cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

8. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the provider/supplier may report an E&M service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For Outpatient Prospective Payment System (OPPS), if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

9. An E&M service, including emergency department E&M, may be reported with a casting/splinting/strapping CPT code if and only if the E&M service is significant and separately identifiable. Casting/splinting/strapping CPT codes are minor surgical procedures with a “000” global day period. Global surgery rules for minor surgical procedures do not allow a provider/supplier to report an E&M service related to deciding whether to perform a minor surgical procedure.

10. There are CPT codes (20670 and 20680) for removal of internal fixation devices (e.g., pin, rod). These codes are not separately reportable if the removal is performed as a necessary integral component of another procedure. For example, if revision of an open fracture repair for nonunion or malunion of bone requires removal of a previously inserted pin, CPT code 20670 or 20680 is not separately reportable.

Similarly, if a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure.

11. CPT code 20670 or 20680 (Removal of implant) shall not be reported for the removal of wire sutures during cardiac reoperation procedures or sternal procedures (e.g., debridement, resection, closure of median sternotomy separation).

12. If a closed reduction procedure fails and is converted to an open reduction procedure at the same patient encounter, only the more extensive open reduction procedure is reportable. Similarly, if a closed fracture treatment procedure fails and is converted to an open fracture treatment procedure at the same patient encounter, only the more extensive open fracture

treatment procedure is reportable.

13. If interdental wiring (e.g., CPT code 21497) is necessary for the treatment of a facial or other fracture, arthroplasty, facial reconstructive surgery, or other facial/head procedure, the interdental wiring is not separately reportable. However, if interdental wiring is performed unrelated to another facial/head procedure, the interdental wiring may be separately reportable with modifier 59 or XU.

14. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not separately reportable.

15. When a fracture or dislocation is repaired, only one fracture/dislocation repair code may be reported. Closed repair codes, percutaneous repair codes, and open repair codes for the same anatomic site are mutually exclusive of one another, and only one of these codes may be reported for the repair of a fracture or dislocation at an anatomic site.

16. If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment without manipulation CPT code may be reported.

Additionally, if a single cast, strapping, or splint treats multiple fractures without manipulation in addition to one or more fracture(s) with manipulation, a closed fracture without manipulation CPT code shall not be reported separately. These policies also apply to the closed treatment of multiple fractures not requiring application of a cast, strapping, or splint. Thus, if multiple closed fractures occur in an area that would have been treated with a single cast, strapping, or splint, only one CPT code for closed fracture treatment without manipulation may be reported.

If a cast, strapping, or splint applied after an open or percutaneous treatment of a fracture also treats a closed fracture without manipulation, a closed fracture without manipulation CPT code shall not be reported separately.

These principles also apply to the treatment of multiple dislocations or combinations of multiple closed fractures and dislocations. If multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported. Additionally, if a single cast, strapping, or splint treats any combination of closed dislocations and/or closed fractures without manipulation in addition to at least one closed dislocation or fracture that did require manipulation, only a single CPT code for closed treatment with manipulation of the dislocation or fracture may be reported.

Similarly, if multiple dislocations and/or fractures are treated with or without manipulation and do not require a cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment CPT code may be reported for the anatomic area that would have been treated by a

single cast, strap, or splint.

Finally, if a cast, strapping, or splint applied after an open or percutaneous treatment of a dislocation and/or fracture also treats a closed dislocation and/or fracture that did not require manipulation, a CPT code for closed dislocation or fracture treatment (without manipulation) shall not be reported separately.

17. When reporting manual therapy techniques (e.g., CPT code 97140) in the anatomic region where a multi-layer compression system (e.g., CPT codes 29581-29584) is applied, it may be necessary to indicate that the manual therapy techniques are distinct from the multi-layer compression system application. Modifier 59 or – X{EPSU} may be appended to either column code.

18. CPT code 20650 (Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)) shall not be reported for insertion of wires or pins without application of skeletal traction. Since the code descriptor includes the "separate procedure" designation, this code shall not be reported for application of skeletal traction with a fracture treatment or other repair code for the same anatomic region.

H. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are 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 (UOS) incorrectly. The provider/supplier may consider contacting their national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. The code descriptors for CPT codes 20670 (Removal of implant; superficial...) and 20680 (Removal of implant; deep...) do not define the unit of service. The Centers for Medicare & Medicaid Services (CMS) allows one unit of service for all implants removed from an anatomic site. This single unit of service includes the removal of all screws, rods, plates, wires, etc., from an anatomic site whether through one or more surgical incisions. An additional unit of service may be reported only if implant(s) are removed from a distinct and separate anatomic site.

4. The MUE values for CPT codes 20931 (Allograft, structural, for spine surgery only...), 20937 (Autograft for spine surgery only...; morselized...), and 20938 (Autograft for spine surgery only...: structural...) are one. Each of these codes may be reported with only one unit of service per operative procedure regardless of the number of vertebral levels fused.

5. Procedures performed on fingers should be reported with modifiers FA, F1-F9,

and procedures performed on toes should be reported with modifiers TA, T1-T9. The MUE values for many finger and toe procedures are one, based on use of these modifiers for clinical scenarios in which the same procedure is performed on more than one finger or toe.

6. 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 unit of service on a single claim line 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. The 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 2 claim lines, each with 1 unit of service using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

7. CPT codes 20600-20611 are a family of codes describing arthrocentesis for aspiration and/or injection of different sized joints or bursae with or without ultrasound guidance. The UOS for each of these codes is a joint and its surrounding bursae, if any. A provider/supplier shall not report more than one unit of service for arthrocentesis of any one joint regardless of whether or not the physician also aspirates or injects one or more of its surrounding bursae. For example, if a physician performs arthrocentesis of the shoulder and 2 bursae of the same shoulder without ultrasound guidance, only 1 unit of service of CPT code 20610 may be reported.

8. CPT codes 21248 and 21249 respectively describe partial or complete reconstruction of the mandible or maxilla with endosteal implant. The unit of service for each of these codes is the reconstruction, not the endosteal implant.

9. A provider/supplier may only report one unit of service of a CPT code describing closed treatment without manipulation of fracture if the same treatment (e.g., cast, splint, strapping) treats fractures of multiple similar bones. For example, if a cast is applied without manipulation to treat fractures of multiple metatarsals of the same foot, only one unit of service of CPT code 28470 may be reported for that treatment. If no cast, splint, or strapping is used for closed treatment without manipulation of multiple similar bones, only one unit of service may be reported for the applicable code.

10. Closed treatment without manipulation of more than one metacarpal bone of the same hand shall be reported with a single unit of service of CPT code 26600 (Closed treatment of metacarpal fracture, single; without manipulation, each bone) regardless of the number of metacarpal bones treated in that one hand. No more than one unit of service of CPT code 26600 per hand may be reported regardless of the number of fractured metacarpal bones in that hand. The same principle applies to closed treatment without manipulation of fractures of multiple

carpal, tarsal, or metatarsal bones in one extremity.

I. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier 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.

2. 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, 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 [e.g., CMS "Internet-Only Manual", Publication 100-04 ("Medicare Claims Processing Manual"), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS "Internet-Only Manual", Publication 100-04 ("Medicare Claims Processing Manual"), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

3. Providers/suppliers reporting services under Medicare's hospital OPPS shall report all services in accordance with appropriate Medicare "Internet-Only Manual (IOM)" instructions.

4. 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".

5. 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 using 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 using tissue adhesive may be reported separately. If a practitioner uses 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 uses 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 the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the "CPT Manual".

6. If a tissue transfer procedure such as a graft (e.g., CPT codes 20900-20924) is included in the code descriptor of a primary procedure, the tissue transfer procedure is not separately reportable. (CPT code 20926 was deleted January 1, 2020).

7. CPT codes 15769 describes excisional harvested grafts of "other" tissues such as fat, dermis, or fascia and CPT codes 15771-15774 describe liposuction harvested grafts of fat. Similar to other graft codes, these codes may not be reported with another code where the code descriptor includes procurement of the graft. Additionally, these CPT codes may be reported only if another graft HCPCS/CPT code does not more precisely describe the nature of the graft.

8. Some procedures routinely use monitoring of interstitial fluid pressure during the postoperative period (e.g., distal lower extremity procedures with risk of anterior compartment compression). CPT code 20950 (Monitoring of interstitial fluid pressure. . .) shall not be reported separately for this monitoring.

9. If electrical stimulation is used to aid bone healing, bone stimulation codes (CPT codes 20974-20975) may be reported. CPT codes 64553-64595 describe procedures for neurostimulators which are used to control pain and shall not be reported for electrical stimulation to aid bone healing. Similarly, the physical medicine electrical stimulation codes (CPT codes 97014 and 97032) shall not be reported for electrical stimulation to aid bone healing.

10. Exploration of the surgical field is a standard surgical practice. Providers/suppliers shall not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 shall not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59 or XS.

11. Debridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable. For example, debridement of muscle and/or bone (CPT codes 11043-11044, 11046-11047) associated with excision of a tumor of bone is not separately reportable. Similarly, debridement of tissue (e.g., CPT codes 11042, 11045, 11720-11721, 97597, 97598) superficial to, but in the surgical field, of a musculoskeletal procedure is not separately reportable. However, debridement of tissue at the site of an open fracture or dislocation may be reported separately with CPT codes 11010-11012.

12. The NCCI program has a PTP edit with Column One CPT code of 24305 (Tendon lengthening, upper arm and elbow, each tendon) and Column Two CPT code of 64718 (Neuroplasty and/or transposition; ulnar nerve at elbow). When performing the tendon lengthening described by CPT code 24305, a neuroplasty of the ulnar nerve is not separately reportable, but a transposition of the ulnar nerve at the elbow is separately reportable. If a provider performs the tendon lengthening described by CPT code 24305 and performs an ulnar

nerve transposition at the elbow described by 64718, the NCCI PTP edit may be bypassed by appending modifier 59 or XU to either column code.

13. Some procedures (e.g., spine) frequently use intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941, and G0453) shall not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure shall not bill other 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package. (CPT code 92585 was deleted January 1, 2021.)

14. CPT codes 28288, 28306, 28307, 28310, and 28315 shall not be reported with bunionectomy CPT codes 28291-28299 for procedures performed on the ipsilateral first toe or metatarsal**.** CPT codes 28306, 28307, and 28310 (Osteotomy procedures) shall not be reported with a bunionectomy code because there are bunionectomy codes that include osteotomy of the first metatarsal or proximal phalanx of the first toe. CPT code 28288 (Ostectomy ...) shall not be reported with a bunionectomy code because it is a misuse of this code to report ostectomy of the median eminence of the metatarsal bone which is integral to the bunionectomy procedure. Additionally, some bunionectomy procedures include excision of the head of the first metatarsal. CPT code 28315 (Sesamoidectomy, first toe (separate procedure)) includes the “separate procedure” designation in its code descriptor. CMS payment policy does not allow separate payment for a procedure designated as a “separate procedure” when performed along with another procedure in the same anatomic area.

15. CPT codes 28008, 28060, 28062, 28250 and 29893 describe procedures that may be performed on plantar fascia. No 2 codes from this group shall be reported for treatment of plantar fascia of the ipsilateral foot at the same patient encounter.

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

17. Arthrocentesis procedures (e.g., CPT codes 20600- 20611) shall not be reported separately with an open or arthroscopic joint procedure when performed on the same joint. However, if an arthrocentesis procedure is performed on one joint and an open or arthroscopic procedure is performed on a different joint, the arthrocentesis procedure may be reported separately.

18. CPT codes 24361 (Arthroplasty, elbow; with distal humeral prosthetic replacement) and 24363 (Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)) include removal of native joint or a failed prosthesis and replacement with a new prosthesis. CPT code 24160 (Removal of prosthesis...humeral and ulnar

components) shall not be reported separately with CPT codes 24361 or 24363 for removal of a prior failed prosthetic joint.

CPT codes 23470 (Arthroplasty, glenohumeral joint; hemiarthroplasty) and 23472 (Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))) include removal of native joint or a failed prosthesis and replacement with a new prosthesis. CPT codes 23333 (Removal of foreign body, shoulder; deep (subfascial or intramuscular)), 23334 (Removal of prosthesis, includes debridement and synovectomy when performed; humeral **or** glenoid component), or 23335 (Removal of prosthesis, includes debridement and synovectomy when performed; humeral **and** glenoid components (e.g., total shoulder)) shall not be reported separately with CPT codes 23470 or 23472 for removal of a prior failed prosthetic joint.

19. With 3 exceptions (Chapter IV, Section E, Subsection 7) an NCCI PTP edit code pair consisting of 2 codes describing 2 shoulder procedures shall not be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder. This type of edit may be bypassed only if the 2 procedures are performed on contralateral shoulders.

20. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96379) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

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/suppliers shall not report CPT codes 96360-96379 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, 62320-62327, 64400-64489, and 96360-96379 describe some services that may be used 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 96360-96379) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96379) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

21. With limited exceptions, open or arthroscopic procedures performed on a joint include debridement (open or arthroscopic) if performed. A debridement code may be reported with a joint procedure code only if the debridement is performed on a different joint or at a site unrelated to the joint. See Section E (Arthroscopy) for discussion of exceptions.

22. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (Insertion of bladder catheters) shall 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.

23. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 shall not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

24. 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 using modifier 78.

25. Fine needle aspiration (FNA) biopsies (CPT codes 10004-10012, and 10021) shall not be reported with another biopsy procedure code for the same lesion. For example, a 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 provider/supplier shall report only one code, either the biopsy code or the FNA code. (CPT code 10022 was deleted January 1, 2019.)

26. If the code descriptor of a HCPCS/CPT code includes the phrase "separate procedure," the procedure is subject to NCCI PTP 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.

27. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the 2 codes of the code pair edit may be reported if the 2 procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 2 codes generally should not be reported together, unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be used.

28. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to,

laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

29. If the code descriptor for a HCPCS/CPT code, "CPT Manual" instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a provider/supplier shall not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

30. CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous, not otherwise specified." These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

31. CPT code 96523 describes "irrigation of implanted venous access…" This code may be reported only if no other service is reported for the patient encounter.