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CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter XI
Medicine
Evaluation and Management Services
CPT Codes 90000 - 99999

A. Introduction

The Medicine section of the *CPT Manual* includes codes for non-invasive or minimally invasive (primarily percutaneous access) services that would not be considered open surgical procedures or evaluation and management services. In keeping with the general principles of correct CPT coding, the services required to accomplish an evaluation or procedure as described by a medicine code descriptor are included in the code and cannot be separately reported even if other specific CPT codes exist to describe these supplemental services. These principles are described in depth in the general policies of Chapter I.

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

The CPT codes 90780-90799 describe services involving therapeutic or diagnostic injections and infusions. The CPT codes 96400-96549 describe administration of chemotherapeutic (primarily antineoplastic) agents. Issues referable to chemotherapy administration will be discussed in this section as well as Section L (Chemotherapy Administration) due to the frequent similarities in administration.

Because the placement of peripheral vascular access devices is integral to vascular (intravenous, intra-arterial) infusions and injections, the CPT codes for placement of these devices are not to be separately reported. Accordingly, routine insertion of an intravenous catheter (e.g. CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g. CPT codes 90780, 90781, 90784, 96408-96412) would be inappropriate. Insertion of central venous access is not routinely necessary to accomplish these services and therefore, could be separately reported. Because intra-arterial infusion usually involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes could be separately reported.

The administration of drugs other than antineoplastic agents, such as growth factors, saline, and diuretics, is reported with

CPT codes 90780-90784. When the sole purpose of fluid administration (e.g. saline, D₅W, etc.) is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic. Therefore, the injection, infusion or chemotherapy administration codes are not to be separately reported. In the case of transfusion of blood or blood products, the insertion of a peripheral IV (e.g. CPT codes 36000, 36410) is routinely necessary and is not separately reported. Administration of fluid in the course of transfusions to maintain line patency or between units of blood products is, likewise, not to be separately reported. If fluid administration is medically necessary for therapeutic reasons (e.g. to correct dehydration, to prevent nephrotoxicity, etc.) in the course of a transfusion or chemotherapy, this could be separately reported with modifier -59 as this is being administered as medically necessary for a different diagnosis.

CPT codes 90782-90788 are status "T" on the Medicare Physician Fee Schedule (MPFS). Therefore, these codes are not separately payable if any other service on the physician fee schedule is payable on that date of service. In compliance with the MPFS, all NCCI edits with column two CPT codes of 90782-90788 do not allow use of NCCI-associated modifiers.

Administration of immunizations not excluded by law are reported with CPT codes 90471 and 90472 and are payable on the MPFS. Thus, separate payment for injections (90782-90788) on the same date of service is prohibited. However, since administration of immunizations for influenza, pneumococcus, and hepatitis B reported as HCPCS Level II codes of G0008-G0010 are payable on a different fee schedule, a separate injection reported as 90782-90788 is additionally payable with G0008-G0010.

Effective January 1, 2004, physician work relative value units equal to that of CPT code 99211 (office visit, established patient, Level 1) were added to drug administration CPT codes 90780-90788, 96400, 96408-96425, 96520, and 96530. Thus, CPT code 99211 cannot be billed with any of these drug administration codes. Other evaluation and management CPT codes may be billed on the same date of service as the drug administration service utilizing modifier -25 to indicate that a significant and separately identifiable evaluation and management service was provided.

C. Psychiatric Services

CPT codes for psychiatric services include general and special diagnostic services as well as a variety of therapeutic services. By *CPT Manual* definition, therapeutic services (e.g. HCPCS/CPT codes 90804-90829) include psychotherapy and continuing medical diagnostic evaluation; therefore, CPT codes 90801 and 90802 are not reported with these services.

Interactive services (diagnostic or therapeutic) are distinct forms of services for patients who have "lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment...". Accordingly, non-interactive services would not be possible at the same session as interactive services and are not to be reported together with interactive services.

Drug management is included in some therapeutic services (e.g. HCPCS/CPT codes 90801-90829, 90845, 90847-90853, 90865-90870) and therefore CPT code 90862 (pharmacologic management) is not to be reported with these codes.

When medical services, other than psychiatric services, are provided in addition to psychiatric services, separate evaluation and management codes cannot be reported. The psychiatric service includes the evaluation and management services provided according to CMS policy.

D. Biofeedback

Biofeedback services involve the use of electromyographic techniques to detect and record muscle activity. The CPT codes 95860-95872 (EMG) should not be reported with biofeedback services based on the use of electromyography during a biofeedback session. If an EMG is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate EMG codes (e.g. CPT codes 95860-95872) may be reported. Modifier -59 should be added to indicate that the service performed was a separately identifiable diagnostic service. Reporting only an objective electromyographic response to biofeedback is not sufficient to bill the codes referable to diagnostic EMG.

E. Gastroenterology

Gastroenterological tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of upper endoscopy (e.g. CPT code 43235); therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) are not separately reported when performed as part of an upper endoscopy. Provocative testing (CPT code 91052) can be expedited during GI endoscopy (procurement of gastric specimens). When performed at the same time as GI endoscopy, CPT code 91052 is reported with modifier -52 indicating that a reduced level of service was performed.

F. Ophthalmology

General ophthalmological services (e.g. CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management codes are reported, these general ophthalmological service codes (e.g. CPT codes 92002-92014) are not to be reported; the same services would be represented by both series of codes.

Special ophthalmologic services represent specific services not described as part of a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services.

For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are necessary to accomplish the procedure and are included in the procedure. Accordingly, HCPCS/CPT codes 36000 (introduction of a needle or catheter), 36410 (venipuncture), 90780 (IV infusion), and 90784 (IV injection) as well as selective vascular catheterization codes are not to be separately reported with services requiring intravenous injection (e.g. CPT codes 92230, 92235, 92240, 92287, for angioscopy and angiography).

G. Otorhinolaryngologic Services

CPT coding for otorhinolaryngologic services involves a number of tests that can be performed qualitatively by confrontation during physical examination or quantitatively with electrical recording equipment. CPT definition specifies which is the case for each code. CPT codes 92552-92557, and 92561-92589 can be performed qualitatively or quantitatively but according to CPT definition

these can be reported only if calibrated electronic equipment is used. Confrontational estimation of these tests by the physician is part of the evaluation and management service.

H. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing (including intracardiac testing) as well as therapeutic services (e.g. electrophysiological procedures). Several unique issues arise due to the spectrum of cardiovascular codes included in this section.

1. When cardiopulmonary resuscitation is performed without other evaluation and management services (e.g. a physician responds to a "code blue" and directs cardiopulmonary resuscitation with the patient's attending physician then resuming the care of the patient after the patient has been revived), only the CPT code 92950 for CPR should be reported. Levels of critical care services and prolonged management services are determined by time; when CPT code 92950 is reported, the time required to perform CPR is not included in critical care or other timed evaluation and management services.

2. In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately reported. A number of therapeutic and diagnostic cardiovascular procedures (e.g. CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intra-arterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate codes for routine access, monitoring, injection or infusion services are not to be reported. Fluoroscopic guidance procedures are integral to invasive intravascular procedures and are included in those services. In unique circumstances, where these services are performed, not as an integral part of the procedure, the appropriate code can be separately reported with modifier -59. When supervision and interpretation codes are identified in the *CPT Manual* for a given procedure, these can be separately reported.

3. Cardiac output measurement (e.g. CPT codes 93561-93562) is routinely performed during cardiac catheterization procedures per CPT definition and, therefore, CPT codes 93561-93562 are not to be reported with cardiac catheterization codes.

4. CPT codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. As this includes all services referable to cardiac rehabilitation, it would be inappropriate to bill a separate evaluation and management service code unless an unrelated, separately identifiable, service is performed and documented in the medical record.

5. When a physician who is in attendance for a cardiac stress test obtains a history, and performs a limited examination referable specifically to the cardiac stress test, a separate evaluation and management service is not reported unless a significant, separately identifiable service is performed unrelated to the performance of the cardiac stress test and in accordance with the evaluation and management guidelines. The evaluation and management service would be reported with modifier -25 in this instance.

6. Routine monitoring of EKG rhythm and review of daily hemodynamics, including cardiac outputs, is a part of critical care evaluation and management. Separate billing for review of EKG rhythm strips and cardiac output measurements (e.g. CPT codes 93040-93042, 93561, 93562) and critical care services is inappropriate. An exception to this may include a sudden change in patient status associated with a change in cardiac rhythm requiring a return to the ICU or telephonic transmission to review a rhythm strip. If reported separately, time included for this service is not included in the critical care time calculated for the critical care service.

7. Percutaneous coronary artery interventions include stent placement, atherectomy, and balloon angioplasty. For reimbursement purposes, Medicare recognizes three coronary arteries: right coronary artery (modifier -RC), left circumflex coronary artery (modifier -LC) and left anterior descending coronary artery (modifier -LD). For a given coronary artery and its branches, the provider should report only one intervention, the most complex, regardless of the number of stent placements, atherectomies, or balloon angioplasties performed in that coronary artery and its branches. From a coding perspective, stent placement is considered more complex than an atherectomy which is considered more complex than a balloon angioplasty. These interventions should be reported with the appropriate modifier (-RC, -LC, -LD) indicating in which coronary artery (including its branches) the procedure(s) was (were) performed.

Since Medicare recognizes three coronary arteries (including their branches) for reimbursement purposes, it is possible that a provider will report up to three percutaneous interventions if an intervention is performed in each of the three coronary arteries or their branches. The first reported procedure must utilize a primary code (CPT codes 92980, 92982, 92995) corresponding to the most complex procedure performed. The procedure(s) performed in the other one or two coronary arteries (including their branches) are reported with the CPT add-on codes (CPT codes 92981, 92984, 92996). Modifier -59 should not be utilized to report percutaneous coronary artery stent placement, atherectomy, or balloon angioplasty.

I. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories. As a result of these code combinations, several issues are addressed in this policy section.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session cannot be separately reported. Specifically, the flow volume loop is an alternative method of calculating a standard spirometric parameter. The CPT code 94375 is included in standard spirometry (rest and exercise) studies.

2. When a physician who is in attendance for a pulmonary function study, obtains a limited history, and performs a limited examination referable specifically to the pulmonary function testing, separately coding for an evaluation and management service is not appropriate. If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be reported.

3. When multiple spirometric determinations are necessary (e.g. CPT code 94070) to complete the service described in the CPT code, only one unit of service is reported.

4. Pulmonary stress testing (e.g. CPT code 94620) is a comprehensive stress test with a number of component tests separately defined in the *CPT Manual*. It is inappropriate to separately code venous access, EKG monitoring, spirometric parameters performed before, during and after exercise, oximetry,

O₂ consumption, CO₂ production, rebreathing cardiac output calculations, etc., when performed as part of a progressive pulmonary exercise test. It is also inappropriate to bill for a cardiac stress test and the component codes used to perform a routine pulmonary stress test, when a comprehensive pulmonary stress test was performed. If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, both a cardiac and pulmonary stress test could be reported. Modifier -59 should be reported with the secondary procedure. In addition, if both tests are reported, both tests must satisfy the requirement for medical necessity.

J. Allergy Testing and Immunotherapy

The *CPT Manual* divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy is divided into codes that include preparation of the antigen when it is administered at the same session and when it is prepared but delivered for immunotherapy by a different physician. Several specific issues are identified regarding allergy testing and immunotherapy.

1. If percutaneous or intracutaneous (intradermal) single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes 95010, 95015, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. Do not report both a single test and a "sequential and incremental" test for the same dilution of an allergen. For example, if the single test for an antigen is positive and the provider proceeds to "sequential and incremental" tests with three additional *different* dilutions of the same antigen, the provider may report one unit of service for the single test code and three units of service for the "sequential and incremental" test code.

2. When photo patch tests (e.g. CPT code 95052) are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be reported. Additionally, if photo testing is performed including application or patch testing, the code for photo patch testing (CPT code 95052) is to be reported, not CPT code 95044 (patch or application tests) and CPT code 95056 (photo tests).

3. Evaluation and management codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered. Obtaining informed consent, is included in the immunotherapy. If E & M services are reported, medical documentation of the separately identifiable service should be in the medical record.

4. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should, therefore, not be reported together. Additionally, the testing becomes an integral part to rapid desensitization kits (CPT code 95180) and would therefore not be reported separately.

K. Neurology and Neuromuscular Procedures

The *CPT Manual* defines codes for neuromuscular diagnostic/therapeutic services not requiring surgical procedures. Sleep testing, nerve and muscle testing and electroencephalographic procedures are included. The *CPT Manual* guidelines regarding sleep testing are very precise and should be reviewed carefully before billing for these services.

1. Sleep testing differs from polysomnography in that the latter requires the presence of sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. Accordingly, at the same session, a "sleep study" and "polysomnography" are not reported together.

2. Polysomnography requires at least one central and usually several other EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (i.e. speed of paper, number of channels, etc.). Accordingly, EEG testing is not to be reported with polysomnography unless performed separately; the EEG tests, if rendered with a separate report, are to be reported with modifier -59, indicating that this represents a different session from the sleep study.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) represent different services than those provided during sleep testing; accordingly these codes are only to be reported when a separately identifiable service is performed and documented. Additionally, billing standard EEG services would only be appropriate if a significant, separately

identifiable service is provided. These codes are to be reported with modifier -59 to indicate that a different service is clearly documented.

4. When nerve testing (EMG, nerve conduction velocity, etc.) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the series of CPT codes 95851-95937 are not to be separately reported; these codes reflect significant, separately identifiable diagnostic services requiring a formal report in the medical record. Additionally, electrical stimulation used to identify or locate nerves as part of a procedure involving treatment of a cranial or peripheral nerve (e.g. nerve block, nerve destruction, neuroplasty, transection, excision, repair, etc.) is part of the primary procedure.

5. Intraoperative neurophysiology testing (CPT code 95920) should 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 should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing since they are also included in the global package.

6. The NCCI edit with column 1 CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column 2 CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 95900 of this NCCI edit is only appropriate if the two procedures are performed on different nerves or in separate patient encounters.

L. Chemotherapy Administration

1. Chemotherapy administration codes include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Prior to January 1, 2004, Medicare payment rules limited the reporting of CPT code 96408 (intravenous push administration of chemotherapy) to one unit of service per day. Effective January 1, 2004, CPT code 96408 can be reported as one unit of service for each drug administered by the intravenous push route. For a given chemotherapeutic agent, only one intravenous (or intra-arterial) route (push or infusion)

is payable at the same patient encounter. It is recognized that combination chemotherapy is frequently provided by different routes at the same session. Modifier -59 can be appropriately used when two different modes of chemotherapy administration are used for different chemotherapeutic agents. Modifier -59 is used in this situation to indicate that two separate procedures are utilized to administer different chemotherapeutic agent(s), not to indicate that two separate agents are administered. (See MCM Section §15400 or online internet manual Pub.100-4,12-§20.9.1.1, 30.5)

2. When infusion of saline, an antiemetic, or any other non-chemotherapy drug is required under CPT codes 90780-90781 and administered at the same time as the chemotherapeutic agents, the former infusions are not separately payable; however, the drugs are payable. If the hydration and/or infusion of antiemetics or any other non-chemotherapy drugs are administered on the same day but sequentially to rather than at the same time as the administration of the chemotherapeutic agents, these infusions are payable with CPT codes 90780-90781 using modifier -59 to indicate that the infusions were administered at different time intervals.

3. In circumstances where a physician has no face-to-face contact with the patient, a physician may report and be paid for "incident to" services in addition to the chemotherapy administration if these services are furnished by one of the physician's employees, under direct supervision in the office by one of the physician's employees, and the medical records reflect that the physician has actively participated in and managed the patient's course of treatment. The "incident to" services in this situation are reported with the evaluation and management code 99211.

4. Flushing of a vascular access port prior to the administration of chemotherapeutic agents is integral to the chemotherapy administration and therefore is not separately reportable.

5. The NCCI edits with column 1 CPT codes 96408 (Intravenous chemotherapy administration by push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column 2 CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 90780 of these NCCI edits is only appropriate

if the 90780 is for hydration, antiemetic, or other non-chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier -59 should not be used for "keep open" infusion for the chemotherapy.

M. Physical Medicine and Rehabilitation

With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a "supervised modality" defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a "timed" CPT code with another "timed" CPT code or a non-timed CPT code. These edits may be bypassed with modifier -59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting "supervised modality" services) even though they should never be reported for the same fifteen minute time period.

NCCI contains edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97002 and 97004 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient's status should change and a re-evaluation is warranted, it may be reported with modifier -59 appended to CPT code 97002 or 97004 as appropriate.

The NCCI edit with column 1 CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column 2 CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 97530 of this NCCI edit is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

N. Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is subject to Global Surgery Rules. Per Medicare Anesthesia Rules a provider performing OMT cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, per Medicare Global Surgery Rules, postoperative pain management after OMT (e.g., nerve block, epidural injection) is not separately reportable. Epidural or nerve block injections performed on the same date of service as OMT and unrelated to the OMT may be reported with OMT using modifier -59.

O. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical therapy services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical therapy services are performed in a different region than CMT and the provider is eligible to report physical therapy codes under the Medicare program, the provider may report CMT and the above physical therapy codes using modifier -59.

P. Miscellaneous Services

1. When CPT code 99175 is reported, observation time provided exclusively to monitor the patient for a response to an emetogenic agent is not to be included in other timed codes (e.g. critical care, office visits, prolonged services, etc.).

2. If hypothermia (e.g. CPT code 99185) is accomplished by regional infusion techniques, separate services for chemotherapy administration should not be reported unless chemotherapeutic agents are also administered at the same session.

3. Therapeutic phlebotomy services (e.g. CPT code 99195) are not to be reported with transfusion service codes (e.g. CPT codes 86890, 86891), plasmapheresis codes, or exchange transfusion codes. Services necessary to perform the phlebotomy (e.g. HCPCS/CPT codes 36000, 36410, 90780, 90781) are included in the procedure.

Q. Evaluation and Management

CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are divided to describe the place of service (e.g. office, hospital, home, nursing facility, emergency department, critical care, etc.) the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.), and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day.

The prolonged physician service with direct face-to-face patient contact, (CPT codes 99354 and 99355) represents an exception and may be used in conjunction with another evaluation and management code. Other services that are described by codes based on the duration of the encounter, such as critical care services, must be reported alone and not with the prolonged service codes.

Evaluation and management services, in general, are cognitive services and significant procedural services are not included in the evaluation and management services. Certain procedural services that arise directly from the evaluation and management service are included as part of the evaluation and management service. Cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, counseling and educational services, among other services are included in evaluation and management services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code. CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

"As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we

believe it is appropriate to bundle it into the payment for the covered E/M encounter."

Because of the intensive nature of caring for critically ill patients, certain services beyond patient history, examination and medical decision making are included in the overall evaluation and management associated with critical care. By CPT definition, services including the interpretation of cardiac output measurements (CPT codes 93561 and 93562), chest X-rays (CPT codes 71010 and 71020), blood gases, and data stored in computers (EKGs, blood pressures, hematologic data), gastric intubation (CPT code 91105), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94656, 94657, 94660, 94662), and vascular access procedures (HCPCS/CPT codes 36000, 36410, 36600) are included in critical care services. Certain sections of CPT codes have incorporated codes describing specialty-specific services which primarily involve evaluation and management. When codes for these services are reported, a separate evaluation and management service described by the series of CPT codes 99201-99499 are not to be reported on the same date. Examples of these codes include general and special ophthalmologic services, general and special diagnostic and therapeutic psychiatric services, among others. Procedural services involve some degree of physician involvement or supervision which is integral to the service; separate evaluation and management services are not reported unless a significant, separately identifiable service is provided. Examples of such procedures include allergy testing and immunotherapy, osteopathic manipulative treatment, physical therapy services, neurologic and vascular testing procedures.

R. General Policy Statements

1. CPT codes 92230 and 92235 (fluorescein angiography and angiography) include injection procedures for angiography.

2. Coronary artery angioplasty, atherectomy, or stenting procedures include insertion of a needle and/or catheter, infusion, fluoroscopy and EKG strips (e.g. CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 90780-90784, 76000-76001, 93040-93042). All are components of performing a coronary artery angioplasty, atherectomy, or stenting.

3. Cardiac catheterization procedures may require procurement of EKG tracings during the procedure to assess chest pain during catheterization and angioplasty; when performed in

this fashion, these EKG tracings are not separately reported. EKGs procured prior to, or after, the procedure may be separately reported with modifier -59.

4. CPT codes 93501, 93505-93545 (cardiac catheterization) include CPT codes 71034, 76000, and 76001 (fluoroscopy).

5. Placement of an occlusive device such as an angioseal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported as HCPCS code G0269. Provider should not report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

6. Renal artery angiography at the time of cardiac catheterization should be reported as HCPCS code G0275 if selective catheterization of the renal artery is not performed. HCPCS code G0275 should not be reported with CPT code 36245 for selective renal artery catheterization or CPT codes 75722 or 75724 for renal angiography. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported.

7. Cardiovascular stress tests include insertion of needle and/or catheter, infusion (pharmacologic stress tests) and EKG strips (e.g. CPT codes 36000, 36410, 90780-90784, 93000-93010, 93040-93042).

8. Ventilation management and continuous positive airway pressure ventilation (CPAP) initiation and management services are mutually exclusive of evaluation and management services with the exception of critical care services. Critical care services (CPT codes 99291-99292) include ventilation management (CPT codes 94656-94657) and CPAP management (CPT codes 94660, 94662).

9. 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, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

10. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. 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), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.