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CHAPTER VIII
SURGERY: ENDOCRINE NERVOUS,
EYE AND OCULAR ADNEXA,
AUDITORY SYSTEMS
CPT CODES 60000 - 69999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VIII
Surgery: Endocrine Nervous,
Eye and Ocular Adnexa,
Auditory Systems
CPT Codes 60000 - 69999

A. Introduction

The section of CPT codes 60000-69979 includes surgical procedures involving the endocrine and nervous systems, procedures involving eye, ocular adnexa, and ear. Because of the number of procedures involved, these sections are subdivided.

In keeping with the general policies introduced earlier, most issues of correct coding can be identified and addressed by reviewing the CPT code definition for the appropriate service.

As a general guideline, when a component service, which is described by a CPT code is necessary to accomplish a more comprehensive service, the component service is assumed to be included in the more comprehensive service; therefore only the more comprehensive service which was performed can be coded.

B. Endocrine and Nervous Systems

1. A burr hole is often necessary in anticipation for intracranial surgery (e.g. craniotomy, craniectomy), either to gain access to intracranial contents, to alleviate pressure in anticipation of further surgery or to place an intracranial pressure monitoring device as part of the surgery. As these services are integral to the performance of the subsequent services, codes representing these services are not to be separately reported if performed at the same session; if performed prior to the comprehensive procedure, modifier -58 can be used to indicate that the burr hole and the intracranial surgery are staged or planned services.

In addition, taps, punctures or burr holes accompanied by drainage procedures (e.g. hematoma, abscess, cyst, etc.) followed by other procedures, are not separately reported unless performed as staged procedures. Modifier -58 may be used to indicate staged or planned services. Many intracranial procedures include bone grafts by CPT definition and these grafts should not be reported separately.

2. Biopsies performed in the course of Central Nervous System (CNS) surgery should not be reported as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field; accordingly it is not appropriate to code an exploratory surgery (e.g. CPT codes 61304, 61305) when another procedure is performed at the same session.

4. When services are performed at the same session, but represent different types of services or are being performed at different sites (see example below), modifier -59 should be added. This modifier indicates that this service was a distinct, separate service and should not be included in the column 1 code.

Example: A patient with an open head injury and a contra-coup subdural hematoma requires a craniectomy for the open head injury and a burr hole drainage on the opposite side for the subdural hematoma. The performance of a burr hole at the time of the craniectomy would be considered part of the craniectomy. However, the contralateral burr hole would be considered a separate service not integral to the craniectomy. To correctly code the burr hole for the contralateral subdural hematoma and the column 1 coded service (the craniectomy), the burr hole should be coded with the appropriate modifier (-59, -RT, -LT, etc.). In this example the correct coding would be CPT codes 61304 with one unit of service and 61154-59 with one unit of service.

5. The use of general intravascular access devices (e.g. intravenous lines, etc.), cardiac monitoring, oximetry, laboratory sample procurement and other routine monitoring for patient safety has been addressed in the previous policy for general anesthesia or monitored anesthesia care (MAC). These policies also apply for procedures that do not require the presence of an anesthesiologist/certified registered nurse anesthetist. As an example, if a physician is performing a spinal puncture for intrathecal injection and administers an anxiolytic agent, but the procedure does not require the presence of an anesthesiologist/certified registered nurse anesthetist, the vascular access and any appropriate monitoring necessary is considered part of the spinal puncture procedure and is not to be reported separately.

6. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure itself. The submission of nerve block or facet block codes for local anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate when there is no independent medical necessity of the administration of local anesthetic except for the lumbar puncture. Separate codes are not to be reported. In comparison, if, in the course of a nerve or other anesthetic block procedure, cerebrospinal fluid is withdrawn, it is inappropriate to bill for a diagnostic lumbar puncture; only the nerve (or other) block should be reported; the CSF procurement is not for diagnostic purposes.

7. The appropriate code for the open treatment of median nerve compression at the wrist (carpal tunnel syndrome) is CPT code 64721; according to *CPT Manual* definition, this includes the open release of the transverse carpal ligament. Additionally, if an arthroscopic procedure (CPT code 29848) fails and must be followed by an open procedure (CPT code 64721), only the open, or successful, procedure can be reported, if necessary, with modifier -22.

8. Nerve repairs by suture or neurorrhaphies (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury to or anastomosis of nerves which are proximally associated (e.g. facial-spinal, facial-hypoglossal, etc.). When neurorrhaphy is performed in conjunction with a nerve graft (CPT codes 64885-64907), a neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., a separate service is not reported for the primary nerve suture.

9. In the same area of the cortex, neurostimulator electrodes can be implanted in only one fashion; accordingly, the CPT code 61850 (burr hole) is included in the CPT code 61860 (craniectomy). Codes describing craniotomy procedures (e.g. CPT codes 62100-62121) are generally bundled into craniectomy codes (e.g. CPT codes 61860-61875).

10. Because procedures necessary to accomplish a column 1 procedure are included in the column 1 procedure, CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive back procedures. Additionally, at the same site, codes describing laminotomy procedures are included in laminectomy

codes. CPT codes 22100-22116 (partial excision of vertebral components) represent distinct procedures, and, accordingly, are not reported with laminotomy/laminectomy procedures unless the services are performed as described in the codes.

11. CPT codes describing the performance of a tracheostomy are not to be reported with the CPT code 61576 (transoral approach to skull base including tracheostomy) as this service is included in the descriptor for the code.

12. The Medicare Carrier Manual Section 15055 (online "Claims Processing Manual", Pub.100-4, 12-§20.4.5) limits the reporting of use of an operating microscope (CPT code 69990) to procedures described by CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898 and 64905-64907. CPT code 69990 should not be reported with other procedures even if an operating microscope is utilized. CMS guidelines for payment of CPT code 69990 differ from *CPT Manual* instructions following CPT code 69990.

C. Ophthalmology

1. When a subconjunctival injection (e.g. CPT code 68200) with a local anesthetic is performed as part of a more extensive anesthetic procedure (e.g. peribulbar or retrobulbar block), a separate service for this procedure is not to be reported. This is a routine part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy, trabeculectomy, and anterior vitrectomy may be performed in conjunction with cataract removal. When an iridectomy is performed in order to accomplish the cataract extraction, it is an integral part of the procedure; it does not represent a separate service, and is not separately reported. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not to be separately reported unless it is medically necessary for a different diagnosis. While a trabeculectomy is not performed as a part of a cataract extraction, it may be performed to control glaucoma at the same time as a cataract extraction. If the procedure is medically necessary at the same time as a cataract extraction, it can be reported under a different diagnosis (e.g. glaucoma). The codes describing iridectomies, trabeculectomies, and anterior vitrectomies, when performed with a cataract

extraction under a separate diagnosis, must be reported with modifier -59. This indicates that the procedure was performed as a different service for a separate situation. The medical record should reflect the medical necessity of the service if separately reported. For example, if a patient presents with a cataract and has evidence of glaucoma, (i.e. elevated intraocular pressure preoperatively) and a trabeculectomy represents the appropriate treatment for the glaucoma, a separate service for the trabeculectomy would be separately reported. Performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not to be separately reported.

3. The various approaches to removing a cataract are mutually exclusive of one another when performed on the same eye.

4. Some retinal detachment repair procedures include some vitreous procedures (e.g. CPT code 67108 includes 67015, 67025, 67028, 67031, 67036, 67039, and 67040). Certain retinal detachment repairs are mutually exclusive to anterior procedures such as focal endolaser photocoagulation (e.g. CPT codes 67110 and 67112 are mutually exclusive to CPT code 67108).

5. CPT codes 68020-68200 (incision, drainage, excision of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362).

6. CPT code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (CPT codes 67917, 67924, 67961, 67966).

7. Correction of lid retraction (CPT code 67911) includes full thickness graft (e.g. CPT code 15260) as part of the total service performed.

8. In the circumstance that it is medically necessary and reasonable to inject sclerosing agents in the same session as surgery to correct glaucoma, the service is included in the glaucoma surgery. Accordingly, codes such as CPT codes 67500, 67515, and 68200 for injection of sclerosing agents (e.g. 5-FU, HCPCS/CPT code J9190) should not be reported with other pressure-reducing or glaucoma procedures.

D. Auditory System

1. When a mastoidectomy is included in the description of an auditory procedure (e.g. CPT codes 69530, 69802, 69910), separate codes describing mastoidectomy are not reported.

2. Myringotomies (e.g. CPT codes 69420 and 69421) are included in tympanoplasties and tympanostomies.

E. General Policy Statements

1. 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.

2. 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.