MEDICARE NATIONAL CORRECT CODING INITIATIVE

CORRESPONDENCE LANGUAGE MANUAL

Effective February 28, 2025

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Introduction

As the largest payer for health care services, CMS-administered programs are a target for improper payments and schemes to defraud federal health care programs of billions of dollars annually.[1] Accurate coding and reporting of services by providers and suppliers is a critical aspect of assuring proper payments. To address this requirement, CMS developed and implemented NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in the Medicare Part B program. The NCCI program has since been expanded to include Medicaid under section 6507 of the Patient Protection and Affordable Care Act.

The NCCI program includes 3 types of edits: Procedure-to Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code (AOC) edits.

- **PTP edits** - prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.
- **MUEs** - prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.
- **AOC edits** - consist of a listing of HCPCS and CPT Add-on Codes with their respective primary codes. An Add-on Code is eligible for payment if and only if one of its primary codes is also eligible for payment.

Claims are denied by NCCI edits based on a determination of inappropriate coding, not on the basis of medical necessity. Correct coding is a separate activity from medical review in that no further clinical judgment is needed to deny a claim; therefore, the denial can be automated. Certain edits also include indicators that certain edits may or may not be bypassed with a modifier.

More detailed information about the Medicare and Medicaid NCCI Programs is available on the National Correct Coding Initiative (NCCI) home page.

Each NCCI PTP edit and MUE has a corresponding Correspondence Language Example Identification Number (CLEID). CLEID tables are only available to Medicare claims processing contractors and provide information about the rationale for these edits that can be used to help educate providers about the edits. For example, a Medicare contractor may refer to the CLEID when responding to an inquiry about a specific NCCI PTP edit or MUE or to an appeal of a claim line that was denied due to an edit. NCCI PTP edit files posted on the Medicare NCCI Procedure to Procedure (PTP) Edits webpage do not include CLEIDs. The following information provides guidance to providers when a Medicare contractor references a CLEID.

[1] See the Department of Health and Human Services Agency Financial Report, https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf

The CLEID is formatted as DD.EEEEEEEEE.

DD identifies the general policy that provides the rationale for the edit. There are fourteen categories of general policies for NCCI PTP edits.

1. Standard preparation/monitoring services for anesthesia
2. HCPCS/CPT procedure code definition
3. CPT Manual or CMS manual coding instruction
4. Mutually exclusive procedures
5. Sequential procedure
6. CPT Separate procedure definition
7. More extensive procedure
8. Reserved for future use
9. Sex-specific procedures
10. Standards of medical/surgical practice
11. Anesthesia service included in surgical procedure
12. Laboratory panel
13. Deleted/modified edits for the NCCI program
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There are 2 categories of general policies for MUEs.

15. MUEs based on units of service (UOS)
16. Deleted/modified edits for MUE(s)

Detailed information about each of the general policies can be found in individual sections of Chapter I of the NCCI Policy Manual for Medicare Services which is posted on the Medicare NCCI Policy Manual webpage. The general correspondence language relating to each of these policy categories is found in this Manual.

EEEEEEEEE identifies the section of this Manual to use for a specific example related to the policy statement. For example, if EEEEEEEEE is 10000, the example refers to Column One CPT codes from the 10000 series of codes in the CPT Manual. For NCCI PTP edits with a Column One HCPCS code of A0000 – V9999, the entry for EEEEEEEEE is A – V rather than a number.

When developing correspondence using the Correspondence Language Manual, Medicare claims processing contractors use two paragraphs from this Manual.

- The first paragraph is the relevant General Correspondence Language statement as identified by DD. For NCCI PTP edits, the Column One and Column Two codes of the edit pair in question are entered in appropriate spaces in that paragraph.
- The second paragraph is the relevant section-specific example as identified by EEEEEEEEE.

For example, for the NCCI PTP edit with a Column One code of 37760 and a Column Two code of 15271, the CLEID is 2.30000. An individual providing an explanation of this edit would use two paragraphs from the Correspondence Language Manual. The first paragraph would be the paragraph 2 HCPCS/CPT procedure code definition from the General Correspondence Language portion of this Manual. The second paragraph would be selected from the Section Specific Examples for the 30000 series of codes, "Respiratory, Cardiovascular, Hemic and Lymphatic Systems". The correspondent would select the example identified as CLEID 2.30000. The two paragraphs would be:

- "The HCPCS/CPT procedure code definition, or descriptor, is based upon contemporary medical practice. When a HCPCS/CPT code is submitted to Medicare, all services described by the descriptor should have been performed. Because some HCPCS/CPT codes describe complex procedures with several components which may under certain circumstances be performed independently, some of the component procedures have their own HCPCS/CPT codes. If a HCPCS/CPT code is reported along with other HCPCS/CPT codes that are components of the descriptor of the first code, only the first code should be reported. The HCPCS/CPT code 37760 descriptor includes the service described by the descriptor of HCPCS/CPT code 15271. Thus, based upon the HCPCS/CPT code descriptors, HCPCS/CPT code 15271 is bundled into HCPCS/CPT code 37760."
- "For example, the code descriptor for CPT code 33612 is "Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction) and the code descriptor for CPT code 33611 is "Repair of double outlet right ventricle with intraventricular tunnel repair." Therefore, based upon the code descriptors the procedure described by CPT code 33611 is a component of the procedure described by CPT code 33612, and CPT code 33611 is bundled into CPT code 33612."

National Correct Coding Initiative General Correspondence Language Policies

1. Standard preparation/monitoring services for anesthesia: Anesthesia services require certain services to prepare a patient before the administration of anesthesia and to monitor a patient during the course of anesthesia. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if needed. The specific services necessary to prepare and monitor a patient vary among procedures based upon the extent of the surgical procedure, the type of anesthesia (general, monitored anesthesia care, regional, local, etc.), and the surgical risk. The physician determines which preparation and monitoring services are used for an anesthesia procedure. These services are included in the anesthesia service. Accordingly, when reporting the anesthesia service code, HCPCS/CPT code _____ (the Column One HCPCS/CPT code), the services described by HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) are included in the anesthesia service.

2. HCPCS/CPT procedure code definition: The HCPCS/CPT procedure code definition, or descriptor, is based upon contemporary medical practice. When a HCPCS/CPT code is submitted to Medicare, all services described by the descriptor should have been

performed. Because some HCPCS/CPT codes describe complex procedures with several components which may under certain circumstances be performed independently, some of the component procedures have their own HCPCS/CPT codes. If a HCPCS/CPT code is reported along with other HCPCS/CPT codes that are components of the descriptor of the first code, only the first code should be reported. The HCPCS/CPT code _____ (the Column One HCPCS/CPT code) descriptor includes the service described by the descriptor of HCPCS/CPT code _____ (the Column Two HCPCS/CPT code). Thus, based upon the HCPCS/CPT code descriptors, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is bundled into HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

3. CPT Manual or CMS manual coding instruction: In addition to CPT procedure code definitions or descriptors, instructions in the CPT Manual are provided either as an introduction to CPT sections or parenthetically. Additionally, CMS issues coding instructions and guidelines in its manuals, program memoranda, and other publications. In the case of HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code), CPT or CMS instructions identify appropriate methodology for code submission and accordingly, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is included in or cannot be reported with HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

4. Mutually exclusive procedures: To provide a sufficiently broad listing of descriptive terms and identifying HCPCS/CPT codes, certain services or procedures are listed which would not reasonably be performed at the same session by the same provider on the same beneficiary. In the case of HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code), it would be unreasonable to expect these services to be performed at a single patient encounter, therefore, these HCPCS/CPT codes have been paired together as edits.

5. Sequential procedure: If a provider attempts several procedures in direct succession at a patient encounter to accomplish the same end, only the procedure that successfully accomplishes the expected result is reported. Generally, this occurs when a less extensive procedure fails and requires the performance of a more extensive procedure. A failed procedure followed by a more extensive procedure should not be reported separately. Procedures that are often performed in sequence have been identified and the less extensive procedure is not separately reportable with the more extensive procedure. When the procedures corresponding to HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) are performed in sequence at the same patient encounter, only HCPCS/CPT code _____ (the Column One HCPCS/CPT code) may be reported.

6. CPT “Separate procedure” definition: The narrative for many HCPCS/CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. A “separate procedure”

should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or surgical approach. HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is designated as a "separate procedure." Therefore, if it is reported with HCPCS/CPT code _____ (the Column One HCPCS/CPT code), HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is bundled into HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

7. More extensive procedure: Some procedures can be performed at varying levels of complexity. The HCPCS/CPT codes corresponding to more extensive procedures always include the HCPCS/CPT codes corresponding to less complex procedures. HCPCS/CPT code _____ (the Column One HCPCS/CPT code) is a more extensive procedure that includes HCPCS/CPT code _____ (the Column Two HCPCS/CPT code). Accordingly, only the more extensive procedure, HCPCS/CPT code _____ (the Column One HCPCS/CPT code) should be reported. HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is bundled into HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

8. Reserved for Future Use

9. Sex-specific procedures: The performance of certain procedures may require significantly different approaches when performed in a male as opposed to a female. Some HCPCS/CPT code descriptors designate these procedures by specifying if the service or procedure is to be reported for a male or a female or by anatomical description. HCPCS/CPT code combinations that describe identical procedures, except that one code describes a procedure for a female and the other describes a procedure for a male, cannot be reported for the same beneficiary by the same provider at the same session. HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) represent such a combination and should not be reported together.

10. Standards of medical/surgical practice: Under Medicare, all services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. Many procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent HCPCS/CPT codes because they may be performed independently in other settings. The service described by HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is typically included when performing the procedure described by HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and is therefore bundled into HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

11. Anesthesia service included in surgical procedure: Pursuant to Medicare's Anesthesiology Rules, Medicare does not pay separately for anesthesia other than moderate conscious sedation under certain circumstances when provided by the same physician who performs the medical or surgical procedure requiring the anesthesia.

HCPCS/CPT codes describing anesthesia services or services that are bundled into anesthesia services should not be reported in addition to the surgical procedure requiring the anesthesia services. Accordingly, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code representing the anesthesia service or service bundled into anesthesia) is included in the surgical service described by HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

12. Laboratory panel: Laboratory panels, described in CPT as "Organ or Disease Oriented Panels," define groupings of laboratory tests that are commonly performed together in clinical practice. When a HCPCS/CPT code describing a panel is reported, HCPCS/CPT codes identifying the individual tests included in the panel should not be reported separately. HCPCS/CPT code _____ (the Column One HCPCS/CPT code representing the laboratory panel) includes HCPCS/CPT code _____ (the Column Two HCPCS/CPT code). Therefore, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is bundled into HCPCS/CPT code _____ (the laboratory panel code or the Column One HCPCS/CPT code).

13. Deleted/modified edits: NCCI edits were developed based upon review of existing local and national edits, review of standards of medical care, review of CPT instructions and descriptors, review of provider billing patterns and Medicare policies. Comments about NCCI PTP edits are received from the AMA and the national medical societies, representatives of the AMA's CPT Editorial Panel, CPT Advisory, and Health Care Professionals Advisory Committees (HCPAC), Contractor Medical Directors, contractor staff, physicians, other providers, and independent billing consultants. Based upon input from these sources, NCCI PTP edits are sometimes deleted. NCCI PTP edits may also be deleted for other reasons such as CMS policies, modified HCPCS/CPT code descriptors or coding instructions, deletion of HCPCS/CPT codes, or modified medical practice. (Occasionally the order of the codes in an edit needs to be reversed. In such situations, the original edit is deleted, and a new edit is added with the order of the codes reversed.) The HCPCS/CPT code pair edit, HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) was deleted from the NCCI program for one of these reasons.

14. Misuse of Column Two code with Column One code: HCPCS/CPT codes have been written as precisely as possible to not only describe a specific procedure but to also avoid describing similar procedures which are already defined by other HCPCS/CPT codes. When a HCPCS/CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Occasionally, a HCPCS/CPT code descriptor will identify certain services that may or may not be included.) A HCPCS/CPT code should not be reported out of the context for which it was intended. When the procedure described by HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is reported with the procedure described by HCPCS/CPT code _____ (the Column One HCPCS/CPT code), reporting the former code represents a misuse of this code, and separate payment is not allowed.

15. Medically Unlikely Edits, Units of Service: Most HCPCS/CPT codes describe procedures that may be reported a maximum number of times by a single provider for the same beneficiary on the same date of service. If a provider bills UOS for HCPCS/CPT codes in excess of established limits, the edits prevent payment. The MUE values are set based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT coding instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment based on input from many sources. MUE values were reviewed by national healthcare organizations before implementation. Most established MUE values have been evaluated with 100% claims data from a 6-month period. CMS publishes most MUE values. However, unpublished MUE values are confidential information for CMS and CMS contractors' use only. No information about unpublished MUE values shall be released or shared outside your organization.

16. Deleted/modified edits: MUEs were developed based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT coding instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and/or clinical judgment. Before implementation, most MUEs were reviewed by national healthcare organizations. Comments about MUEs are received from the AMA and the national healthcare organizations (NHOs), representatives of the AMA's CPT Editorial Panel, CPT Advisory, HCPAC, Medicare Contractor Medical Directors, contractor staff, physicians, other providers, and independent billing consultants. Based upon input from these sources, an MUE may be deleted. MUEs may also be deleted for other reasons such as CMS policies, modified HCPCS/CPT code descriptors or coding instructions, deletion of HCPCS/CPT codes, or modified medical practice. (Occasionally an MUE is modified. In such situations the original MUE is deleted, and a new MUE with the revised MUE value is added). The MUE for the HCPCS/CPT code _____ was deleted or modified for one of these reasons.

National Correct Coding Initiative Medicare Correspondence Language Section-Specific Examples

Anesthesia Services CPT Codes 00000-09999

CLEID 1.00000 - Standard preparation/monitoring services for anesthesia

An example of a "standard preparation/monitoring service" integral to anesthesia services is the placement of an intravenous access line (CPT code 36000) before the administration of general anesthesia. This procedure is necessary to prepare the patient for a general anesthesia procedure and, therefore, is included as a part of the anesthesia service. CPT code 36000 is bundled into all anesthesia service codes.

CLEID 3.00000 - CPT Manual or CMS manual coding instruction

For example, in the CPT Manual instruction under anesthesia for diagnostic arteriography/venography (CPT code 01916), the reference note states: "Do not report 01916 in conjunction with therapeutic codes 01924-01926, 01930-01933." Therefore, CPT code 01916 is

bundled with CPT codes 01924-01926 and 01930-01942.

CLEID 7.00000 - More extensive procedure

For example, CPT code 01830 describes anesthesia for open or surgical arthroscopic/endoscopic procedures on the wrist as well as other sites contiguous to the wrist, and CPT code 01829 describes anesthesia for diagnostic arthroscopic procedures on the wrist. Reporting CPT code 01829 with CPT code 01830 is not appropriate because the procedure described by CPT code 01830 is more extensive than the procedure described by CPT code 01829.

CLEID 14.00000 - Misuse of Column Two code with Column One code

For example, CPT codes 95700-95726 describe continuous electroencephalographic monitoring services. When electroencephalogram (EEG) monitoring is performed during anesthesia for an intracranial procedure (CPT code 00210), reporting this monitoring separately with CPT codes 95700-95726 is a misuse of CPT codes 95700-95726. Intraoperative EEG monitoring is integral to anesthesia services for intracranial procedures. Therefore, CPT codes 95700-95726 are not reported separately with CPT code 00210.

CLEID 15.00000 - Medically Unlikely Edits, Units of Service

For example, CPT code 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration) by definition includes management of epidural or subarachnoid continuous drug administration for an entire day. This code may be reported with only one unit of service for a single date of services. If UOS in excess of one are reported, the MUE prevents payment.

MUE UOS do not apply to Anesthesia Services (CPT codes 00100-01992).

Integumentary System CPT Codes 10000-19999

CLEID 2.10000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 19302 is “Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy,” and the code descriptor for CPT code 19301 is “Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy).” Therefore, based upon the code descriptors the procedure described by CPT code 19301 is a component of the procedure described by CPT code 19302.

CLEID 3.10000 - CPT Manual or CMS manual coding instruction

For example, the CPT Manual instruction under “Excision - Benign Lesions,” states that the excision includes simple closure. Therefore, the procedure described by the Column One CPT code 11400 *(*Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms, or legs; excised diameter 0.5 cm or less) includes the procedure described by the Column Two CPT code 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5cm or less). CPT code 12001 is bundled into CPT code 11400.

CLEID 4.10000 - Mutually exclusive procedures

For example, CPT code 17260 describes the destruction of a malignant lesion, trunk, arms or legs; lesion diameter 0.5 cm or less. CPT code 11600 describes the excision of a malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less. Only one method of treatment of the malignant skin lesion would be performed at a single patient encounter. Therefore, CPT codes 17260 and 11600 are mutually exclusive of each other.

CLEID 5.10000 - Sequential procedure

For example, CPT code 10021 describes a fine needle aspiration biopsy without imaging guidance. CPT code 19101 describes an open incisional biopsy of the breast. If a fine needle aspiration biopsy of a breast lesion is unsuccessful and the physician sequentially performs an incisional biopsy of the same lesion at the same patient encounter, only the successful open incisional biopsy may be reported. Therefore, CPT code 10021 is not separately reportable with CPT code 19101.

CLEID 6.10000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 19100 (Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)) includes the “separate procedure” designation. When an excision of a breast lesion (CPT code 19125) is performed on the same breast, the procedure described by CPT code 19100 does not meet the definition of a “separate procedure”. Therefore, CPT code 19100 cannot be reported separately when both services are performed on the same breast.

CLEID 7.10000 - More extensive procedure

For example, CPT code 19307 describes a modified radical mastectomy which removes the entire breast and axillary adipose tissue. Although the primary purpose of a radical mastectomy is generally the treatment of a malignant lesion, other lesions in the breast such as cysts are also removed. Separate reporting of CPT code 19120, which describes excision of benign breast lesions such as cysts, is not appropriate with CPT code 19307 for the same breast because the latter represents the more extensive procedure.

CLEID 10.10000 - Standards of medical/surgical practice

For example, blepharoplasty of the upper eyelid (CPT code 15822) includes repair of the incision (CPT code 12011) as a standard of medical/surgical practice. Therefore, CPT code 12011 is bundled into CPT code 15822.

CLEID 11.10000 - Anesthesia service included in surgical procedure

For example, when an avulsion of a nail plate (CPT code 11730 Avulsion of nail plate, partial or complete, simple; single) is performed, anesthesia may be provided by the surgeon using a digital nerve block (CPT code 64450 Injection of anesthetic agent and/or steroid into other peripheral nerve or branch). Because this type of anesthesia provided by the surgeon performing the procedure is not separately reportable, CPT code 64450 is bundled into CPT code 11730 when performed for anesthesia by the same physician.

CLEID 14.10000 - Misuse of Column Two code with Column One code

For example, CPT code 11900 (Intralesional injection) describes a therapeutic cutaneous intralesional injection. It is a misuse of this code to report it for the injection of local anesthesia in order to perform another procedure such as an excision of a benign skin lesion (CPT code 11400). Therefore, CPT code 11900 is not reported separately.

CLEID 15.10000 - Medically Unlikely Edits, Units of Service

For example, CPT code 11719 (Trimming of nondystrophic nails, any number) by definition includes any number of nails. This code may be reported only once for a patient on any single date of service by the same provider. If UOS in excess of one are reported, the MUE prevents payment.

Musculoskeletal System CPT Codes 20000-29999

CLEID 2.20000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 21045 is “Excision of malignant tumor of mandible; radical resection,” and the code descriptor for CPT code 21044 is “Excision of malignant tumor of mandible.” Therefore, based upon the code descriptors the procedure described by CPT code 21044 is a component of the procedure described by CPT code 21045.

CLEID 3.20000 - CPT Manual or CMS manual coding instruction

For example, the parenthetical note following CPT code 20611 states: “Do not report 20610, 20611 in conjunction with 27369, 76942.” Thus, CPT codes 27369 and 76942 should not be reported with arthrocentesis procedures described by CPT codes 20610 and 20611.

CLEID 4.20000 - Mutually exclusive procedures

For example, CPT codes 27441 and 27442 describe different types of knee arthroplasties of the tibial plateau. CPT code 27441 describes the procedure on the tibial plateau with debridement and partial synovectomy and CPT code 27442 describes the procedure on femoral condyles or the tibial plateau(s). Since both procedures would not be performed on the same knee at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 5.20000 - Sequential procedure

For example, if an initial deep bone biopsy by needle or trocar (CPT code 20225) is unsuccessful and is followed by an open biopsy (CPT code 20250) at the same patient encounter, only CPT code 20250 may be reported. Therefore, CPT code 20225 is not separately reportable with CPT code 20250.

CLEID 6.20000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 29870 (Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)) includes the “separate procedure” designation. When a surgical arthroscopy of the knee with major synovectomy in 2 or more compartments

(CPT code 29876) is performed on the same knee, the procedure described by CPT code 29870 does not meet the definition of a “separate procedure.” Therefore, CPT code 29870 cannot be reported separately when both services are performed on the same knee.

CLEID 7.20000 - More extensive procedure

For example, CPT code 21012 describes excision of a subcutaneous soft tissue tumor of the face or scalp that measures 2 cm or more. CPT code 21011 describes excision of a subcutaneous soft tissue tumor of the face or scalp that measures less than 2 cm. Excision of a tumor greater than 2 cm or more (CPT code 21012) is more extensive than excision of a tumor less than 2 cm (CPT code 21011) when performed at the same anatomic site.

CLEID 10.20000 - Standards of medical/surgical practice

For example, CPT code 25115 describes a radical excision of a bursa or synovia of the wrist. It is standard surgical practice to preserve neurologic function by isolating and freeing nerves as necessary. A neuroplasty (e.g., CPT code 64719) should not be reported separately for this process. Therefore, CPT code 64719 is bundled into CPT code 25115.

CLEID 11.20000 - Anesthesia service included in surgical procedure

For example, when a small joint or bursa arthrocentesis, aspiration and/or injection (CPT code 20600) is performed, anesthesia may be provided by the surgeon using a digital nerve block (CPT code 64450). Because this type of anesthesia provided by the surgeon performing the procedure is not separately payable, CPT code 64450 is bundled into CPT code 20600 when the same physician performs both procedures.

CLEID 14.20000 - Misuse of Column Two code with Column One code

For example, CPT code 20550 (Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar “fascia”)) describes a therapeutic musculoskeletal injection. It is a misuse of this code to report it for the injection of local anesthesia in order to perform another procedure such as a hallux valgus correction (CPT code 28292). Therefore, CPT code 20550 is not reported separately.

CLEID 15.20000 - Medically Unlikely Edits, Units of Service

For example, CPT code 27440 (Arthroplasty, knee, tibial plateau) may only be performed on a knee once on a single date of service. If performed on a single knee, this procedure would be reported with one unit of service. If this procedure is performed bilaterally, it should be reported with modifier 50 and one unit of service. If UOS in excess of one are reported, the MUE prevents payment.

Respiratory System, Cardiovascular System, Hemic and Lymphatic Systems, Mediastinum and Diaphragm CPT Codes 30000-39999

CLEID 2.30000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 33612 is “Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction,” and the code descriptor for CPT code 33611 is “Repair of double outlet right ventricle with intraventricular tunnel repair.” Therefore, based upon the code descriptors the procedure described by CPT code 33611 is a component of the procedure described by CPT code 33612.

CLEID 3.30000 - CPT Manual or CMS manual coding instruction

For example, CPT code 33645 describes a direct or patch closure of the sinus venosus with or without anomalous pulmonary venous drainage. The CPT Manual instruction below CPT code 33645 states: “Do not report 33645 in conjunction with 33724, 33726.” Therefore, CPT code 33724 which describes a repair of isolated partial anomalous pulmonary venous return may not be reported in addition to CPT code 33645.

CLEID 4.30000 - Mutually exclusive procedures

For example, CPT codes 33820 and 33822 describe different types of repairs of a patent ductus arteriosus. CPT code 33820 describes a patent ductus arteriosus repair by ligation, and CPT code 33822 describes a patent ductus arteriosus repair by division. Since both procedures would not be performed on a patent ductus arteriosus at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 5.30000 - Sequential procedure

For example, if a surgical endoscopic operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure), without cardiopulmonary bypass (CPT code 33265) is unsuccessful and is followed at the same patient encounter by an open operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure) (CPT code 33254), only CPT code 33254 may be reported. Therefore, CPT code 33265 is not separately reportable with CPT code 33254.

CLEID 6.30000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 33210 (Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)) includes the “separate procedure” designation. When a coronary artery bypass with single arterial graft procedure (CPT code 33533) is performed, the procedure described by CPT code 33210 does not meet the definition of a “separate procedure.”

CLEID 7.30000 - More extensive procedure

For example, CPT code 32663 describes thoracoscopy with lobectomy of a single lobe. CPT code 32671 describes thoracoscopy with removal of the entire lung (pneumonectomy). Since the right lung has 3 lobes and the left lung has 2 lobes, a pneumonectomy (CPT code 32671) is a more extensive procedure than a lobectomy (CPT code 32663).

CLEID 10.30000 - Standards of medical/surgical practice

For example, CPT code 30160 describes a total rhinectomy. CPT code 30110 describes simple

excision of a nasal polyp(s). If nasal polyps are present when a total rhinectomy is performed, excision of the polyp(s) is an inherent component of the rhinectomy. Therefore, CPT code 30110 should not be reported separately with CPT code 30160.

CLEID 11.30000 - Anesthesia service included in surgical procedure

For example, when direct operative laryngoscopy with foreign body removal is performed (CPT code 31530) and anesthesia is also performed by the surgeon (CPT code 00320), separate reporting for the anesthesia service is inappropriate. Therefore, CPT code 00320 is bundled into CPT code 31530.

CLEID 14.30000 - Misuse of Column Two code with Column One code

For example, CPT code 35226 (Repair blood vessel, direct; lower extremity) describes an open blood vessel repair of the lower extremity. It is a misuse of CPT code 35226 to report it for the repair of the site where a percutaneous intra-aortic balloon assist device is removed (CPT code 33968). Therefore, CPT code 35226 is not reported separately.

CLEID 15.30000 - Medically Unlikely Edits, Units of Service

For example, CPT code 31603 (Tracheostomy, emergency procedure; transtracheal) may be reported with a maximum of one unit of service on a single date of service since there is one trachea. If UOS in excess of one are reported, the MUE prevents payment.

Digestive System CPT Codes 40000-49999

CLEID 2.40000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 45805 is “Closure of rectovesical fistula; with colostomy,” and the code descriptor for CPT code 45800 is “Closure of rectovesical fistula.” Therefore, based upon the code descriptors the procedure described by CPT code 45800 is a component of the procedure described by CPT code 45805.

CLEID 3.40000 - CPT Manual or CMS manual coding instruction

For example, the CPT Manual instruction below CPT 42975 states: “Do not report 42975 in conjunction with 31575, 92511.” Therefore, CPT code 42975 (Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic) should not be reported separately with CPT code 31575 (Laryngoscopy, flexible; diagnostic).

CLEID 4.40000 - Mutually exclusive procedures

For example, CPT codes 43100 and 43101 describe different approaches to the excision of an esophageal lesion. CPT code 43100 describes a cervical approach, and CPT code 43101 describes a thoracic or abdominal approach. Since both procedures would not be performed at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 5.40000 - Sequential procedure

For example, if an anoscopy with control of bleeding (CPT code 46614) is unsuccessful and is followed by a complex or an extensive internal and external hemorrhoidectomy (CPT code 46260), only CPT code 46260 may be reported. Therefore, CPT code 46614 is not separately reportable with CPT code 46260.

CLEID 6.40000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 44005 (Enterolysis (freeing of intestinal adhesion) (separate procedure)) includes the “separate procedure” designation. When a partial colectomy with anastomosis (CPT code 44140) is performed, the procedure described by CPT code 44005 does not meet the definition of a “separate procedure.” Therefore, CPT code 44005 cannot be reported separately.

CLEID 7.40000 - More extensive procedure

For example, CPT code 42426 describes excision of a parotid tumor or total parotid gland with unilateral radical neck dissection. CPT code 42425 describes excision of a parotid gland tumor without a radical neck dissection. The procedure described by CPT code 42426 is more extensive than the procedure described by CPT code 42425.

CLEID 10.40000 - Standards of medical/surgical practice

For example, during a tonsillectomy (CPT code 42821) bleeding may occur. The control of such bleeding intraoperatively is a standard of surgical practice. It is inappropriate to report separately CPT code 42961 (control of oropharyngeal hemorrhage). Therefore, CPT code 42961 is bundled into CPT code 42821.

CLEID 11.40000 - Anesthesia service included in surgical procedure

For example, if an ilioinguinal or iliohypogastric nerve block (CPT code 64425) is performed for anesthesia by the physician performing an inguinal hernia repair (CPT code 49505), the nerve block is included in the surgical procedure and is not reported separately. Therefore, CPT code 64425 is bundled into CPT code 49505.

CLEID 14.40000 - Misuse of Column Two code with Column One code

For example, CPT code 49322 describes a surgical laparoscopy with aspiration of single or multiple cavities or cysts (e.g., ovarian cyst). CPT code 49082 describes an abdominal paracentesis (diagnostic or therapeutic) without imaging guidance. It is a misuse of CPT code 49082 to report it in addition to CPT code 49322 at the same patient encounter since the procedure described by CPT code 49322 includes the procedure described by CPT code 49082.

CLEID 15.40000 - Medically Unlikely Edits, Units of Service

For example, CPT code 44950 (Appendectomy) may be reported with a maximum of one unit of service since there is only one appendix. If UOS in excess of one are reported, the MUE prevents payment.

Urinary System, Male Genital System, Intersex Surgery, Female Genital System, Maternity Care and Delivery CPT Codes 50000-59999

CLEID 2.50000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 51925 is “Closure of vesicouterine fistula; with hysterectomy,” and the code descriptor for CPT code 51920 is “Closure of vesicouterine fistula.” Therefore, based upon the code descriptors the procedure described by CPT code 51920 is a component of the procedure described by CPT code 51925.

CLEID 3.50000 - CPT Manual or CMS manual coding instruction

For example, the parenthetical note following CPT code 58146 states: “Do not report 58146 in addition to 58140-58145, 58150-58240.” Therefore, CPT code 58146 is not separately reportable with CPT code 58150.

CLEID 4.50000 - Mutually exclusive procedures

For example, CPT codes 50800 and 50860 describe different types of ureteral diversion procedures. CPT code 50800 describes diversion to the intestine, and CPT code 50860 describes diversion to the skin (ureterostomy). Since both procedures would not be performed on the same ureter at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 5.50000 - Sequential procedure

For example, if a needle or punch biopsy of the prostate by any approach (CPT code 55700) is unsuccessful and is followed at the same patient encounter by an incisional biopsy of the prostate (CPT code 55705), only CPT code 55705 may be reported. Therefore, CPT code 55700 is bundled into CPT code 55705.

CLEID 6.50000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 49000 (Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)) includes the “separate procedure” designation. When a total abdominal hysterectomy, with or without removal of tubes and/or ovaries (CPT code 58150) is performed, the procedure described by CPT code 49000 does not meet the definition of a “separate procedure.” Therefore, CPT code 49000 cannot be reported separately.

CLEID 7.50000 - More extensive procedure

For example, CPT code 54530 describes a radical orchiectomy through an inguinal approach. Since a partial orchiectomy (CPT code 54522) removes a smaller portion of the testis, the procedure described by CPT code 54530 is more extensive than the one described by CPT code 54522.

CLEID 9.50000 - Sex-specific procedures

For example, CPT code 52270 describes a cystourethroscopy with an internal urethrotomy for a

female, and CPT code 52275 describes the identical procedure for a male. The 2 procedures cannot be reported for the same beneficiary. Therefore, only the appropriate code should be reported.

CLEID 10.50000 - Standards of medical/surgical practice

For example, CPT code 51820 describes a cystourethroplasty with unilateral or bilateral ureteroneocystostomy. CPT code 51701 describes an insertion of a non-indwelling bladder catheter and may be performed as a standard of medical/surgical practice before performing a cystourethroplasty with ureteroneocystostomy (CPT code 51820). Therefore, CPT code 51701 is bundled into CPT code 51820.

CLEID 11.50000 - Anesthesia service included in surgical procedure

For example, when an incision and drainage of a Bartholin's gland abscess (CPT code 56420) is performed and anesthesia is also performed by the surgeon (CPT code 00940), separate reporting for the anesthesia service is inappropriate. Therefore, CPT code 00940 (Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified) is bundled into CPT code 56420.

CLEID 14.50000 - Misuse of Column Two code with Column One code

For example, an incidental appendectomy during another intra-abdominal surgical procedure should not be reported separately. It is a misuse of CPT code 44950 (Appendectomy) to report it for an incidental appendectomy during the procedure described by CPT code 58150 (Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)). Therefore, CPT code 44950 is bundled into CPT code 58150.

CLEID 15.50000 - Medically Unlikely Edits, Units of Service

For example, CPT code 55840 (Prostatectomy, retropubic radical, with or without nerve sparing) may be reported with a maximum of one unit of service because there is only one prostate gland in males. If UOS in excess of one are reported, the MUE prevents payment.

Endocrine System, Nervous System, Eye and Ocular Adnexa, Auditory System, Operating Microscope CPT Codes 60000-69999

CLEID 2.60000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 67039 is "Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation," and the code descriptor for CPT code 67036 is "Vitrectomy, mechanical, pars plana approach." Therefore, based upon the code descriptors the procedure described by CPT code 67036 is a component of the procedure described by CPT code 67039.

CLEID 3.60000 - CPT Manual or CMS manual coding instruction

For example, CPT code 66711 describes a ciliary body destruction; cyclophotocoagulation,

endoscopic, without concomitant removal of crystalline lens. The CPT Manual instruction following CPT code 66711 states: “Do not report 66711 in conjunction with 66990.” Therefore, CPT code 66990 for use of ophthalmic endoscope is bundled into CPT code 66711.

CLEID 4.60000 - Mutually exclusive procedures

For example, CPT codes 69433 and 69436 describe different types of tympanostomy requiring insertion of ventilating tube. CPT code 69433 describes the procedure performed with local or topical anesthesia, and CPT code 69436 describes the procedure performed with general anesthesia. Since both procedures would not be performed at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 5.60000 - Sequential procedure

For example, if a fine needle aspiration of the thyroid (CPT code 10021) is unsuccessful and is followed at the same patient encounter by a percutaneous core needle biopsy of the thyroid (CPT code 60100), only CPT code 60100 may be reported. Therefore, CPT code 10021 is not separately reportable with CPT code 60100.

CLEID 6.60000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 67715 (Canthotomy (separate procedure)) includes the “separate procedure” designation. When a construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy (CPT code 67880) is performed on the same eye, the procedure described by CPT code 67715 does not meet the definition of a “separate procedure.” Therefore, CPT code 67715 may not be reported separately with CPT code 67880 for the same eye.

CLEID 7.60000 - More extensive procedure

For example, CPT code 67228 describes treatment of extensive or progressive diabetic retinopathy by photocoagulation. CPT code 67208 describes destruction of a localized retinal lesion by cryotherapy. The procedure described by CPT code 67228 is more extensive than the procedure described by CPT code 67208.

CLEID 10.60000 - Standards of medical/surgical practice

For example, CPT code 60240 describes a total or complete thyroidectomy. CPT code 60500 describes a parathyroidectomy or exploration of parathyroid(s). The exploration of parathyroid glands with or without parathyroidectomy (CPT code 60500) is standard surgical practice when performing a complete thyroidectomy (CPT code 60240). Therefore, CPT code 60500 is bundled into CPT code 60240.

CLEID 11.60000 - Anesthesia service included in surgical procedure

For example, if the surgeon performing a cataract extraction (CPT code 66984) also provides anesthesia (CPT code 00142), the anesthesia service is not reported separately. Therefore, CPT code 00142 is bundled into CPT code 66984.

CLEID 14.60000 - Misuse of Column Two code with Column One code

For example, CPT code 20550 (Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")) describes a therapeutic musculoskeletal injection. It is a misuse of this code to report it for the injection of local anesthesia in order to perform another procedure such as a carpal tunnel release (CPT code 64721).

CLEID 15.60000 - Medically Unlikely Edits, Units of Service

For example, CPT code 62292 (Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar) by definition includes treatment at "single or multiple levels" of the lumbar spine. If UOS in excess of one are reported, the MUE prevents payment.

Radiology Services CPT Codes 70000-79999

CLEID 2.70000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 71270 is "Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections," and the code descriptor for CPT code 71260 is "Computed tomography, thorax, diagnostic; with contrast material(s)." Therefore, based upon the code descriptors the procedure described by CPT code 71260 is a component of the procedure described by CPT code 71270.

CLEID 3.70000 - CPT Manual or CMS manual coding instruction

For example, CPT code 70332 describes radiological supervision and interpretation of a temporomandibular joint arthrogram. The CPT Manual instruction following CPT code 70332 states: "Do not report 70332 in conjunction with 77002." Therefore, CPT code 77002 (Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device (List separately in addition to code for primary procedure)) is bundled into CPT code 70332.

CLEID 4.70000 - Mutually exclusive procedures

For example, CPT codes 74250 and 74251 describe radiologic examination of the small intestine. CPT code 74250 includes single contrast whereas CPT code 74251 includes double contrast. The CPT Manual instruction following CPT code 74251 states: "Do not report 74251 in conjunction with 74248, 74250." Both procedures should not be performed at the same patient encounter.

CLEID 6.70000 - CPT "separate procedure" definition

For example, the code descriptor for CPT code 76000 (Fluoroscopy (separate procedure), up to 1-hour physician or other qualified health care professional time) includes the "separate procedure" designation. When radiological supervision and interpretation (RS&I) for percutaneous transhepatic portography with hemodynamic evaluation (CPT code 75885) is performed, the procedure described by CPT code 76000 does not meet the definition of a "separate procedure." Therefore, CPT code 76000 cannot be reported separately with CPT code

75885 for the same anatomic site at the same patient encounter on the same date of service.

CLEID 7.70000 - More extensive procedure

For example, CPT code 72240 describes RS&I for cervical myelography. CPT code 72270 describes RS&I for myelography of 2 or more spinal regions (i.e. cervical/thoracic region, lumbar/thoracic region, lumbar/cervical region). If the myelography RS&I performed includes 2 or more spinal regions, one of which is the cervical region, the procedure described by CPT code 72270 is more extensive than the one described by CPT code 72240.

CLEID 10.70000 - Standards of medical/surgical practice

For example, CPT code 74170 describes an abdominal CT scan requiring intravenous administration of contrast. Since intravenous insertion of a catheter (CPT code 36000) is a standard medical/surgical practice to infuse the contrast, CPT code 36000 is bundled into CPT code 74170.

CLEID 11.70000 - Anesthesia service included in surgical procedure

For example, if the physician performing magnetic resonance imaging of the cervical spinal canal without contrast material (CPT code 72141) also provides anesthesia for the non-invasive imaging (CPT code 01922), the anesthesia service is not reported separately. Therefore, CPT code 01922 is bundled into CPT code 72141.

CLEID 14.70000 - Misuse of Column Two code with Column One code

For example, CPT code 33016 (Pericardiocentesis, including imaging guidance, when performed) is bundled with CPT code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation). Since imaging supervision and interpretation codes include all radiological services necessary to complete the service, it is a misuse of CPT code 76942 to report it separately with CPT code 33016.

CLEID 15.70000 - Medically Unlikely Edits, Units of Service

For example, CPT code 77080 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton . . .) may be reported with a maximum of one unit of service because the code descriptor includes all axial skeletal sites and the test would only be performed once on a single date of service. If UOS in excess of one are reported, the MUE prevents payment.

Pathology and Laboratory Services CPT Codes 80000-89999

CLEID 2.80000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 80192 is “Procainamide; with metabolites (eg, n-acetyl procainamide),” and the code descriptor for CPT code 80190 is “Procainamide.” Therefore, based upon the code descriptors the procedure described by CPT code 80190 is a component of the procedure described by CPT code 80192.

CLEID 3.80000 - CPT Manual or CMS manual coding instruction

For example, CPT codes 86920 and 86923 describe different types of blood compatibility testing. The CPT Manual instruction following CPT code 86923 states: “Do not use 86923 in conjunction with 86920-86922 for same unit crossmatch.” Therefore, CPT code 86923 cannot be reported with CPT codes 86920, 86921 and/or 86922 for compatibility testing of the same unit of blood.

CLEID 4.80000 - Mutually exclusive procedures

For example, CPT codes 81000 and 81001 describe different ways of performing urinalysis with microscopy. The procedure described by CPT code 81000 uses a manual process with dip stick or tablet reagent, and the procedure described by CPT code 81001 uses an automated process. Since both procedures would not be performed on the same urine specimen at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 7.80000 - More extensive procedure

For example, CPT code 80503 describes a clinical pathology consultation that includes limited review of patient’s history and medical records and straightforward medical decision making. When using time for code selection for CPT 80503, 5-20 minutes of total time is spent on the date of consultation. CPT code 80504 describes a clinical pathology consultation that includes a review of patient's history and medical records and moderate level medical decision making. When using time for code selection for CPT 80504, 21-40 minutes of total time is spent on the date of consultation. The procedure described by CPT code 80504 is more extensive than the procedure described by CPT code 80503.

CLEID 10.80000 - Standards of medical/surgical practice

For example, CPT code 82575 describes creatinine clearance, and CPT code 82565 describes blood creatinine. Since determination of creatinine clearance (CPT code 82575) requires measurement of the blood creatinine (CPT code 82565) in addition to urine creatinine and 24-hour urine volume, the measurement of blood creatinine is included in the creatinine clearance as a standard of medical/surgical practice. Therefore, CPT code 82565 is bundled into CPT code 82575.

CLEID 12.80000 - Laboratory panel

For example, CPT code 80076 describes a hepatic function panel which includes 7 specific laboratory tests. If all 7 individual tests are performed at the same patient encounter, the hepatic function panel (CPT code 80076) may be reported. If 1 or more of the 7 specific laboratory tests such as serum albumin (CPT code 82040) is additionally reported, it represents duplicate reporting of the laboratory test. Therefore, CPT code 82040 is bundled into CPT code 80076 when performed on the same specimen.

CLEID 14.80000 - Misuse of Column Two code with Column One code

For example, the professional component CPT code 88141 describes the physician interpretation of a diagnostic cervical or vaginal cytopathology specimen and may be reported with technical

component CPT codes for diagnostic cervical or vaginal cytopathology such as CPT codes 88142-88153, 88164-88167, and 88174-88175. CPT code 88141 should not be reported with HCPCS codes for screening cervical or vaginal cytopathology such as G0143. It is a misuse of CPT code 88141 to report a physician interpretation of a screening cervical or vaginal cytopathology specimen reported as HCPCS code G0143.

CLEID 15.80000 - Medically Unlikely Edits, Units of Service

For example, CPT code 83036 describes a test for Hemoglobin A1C (glycosylated hemoglobin). Since this analyte is a measure of blood glucose control over the prior 3 months, it would be measured at most once on a single date of service. If UOS in excess of one are reported, the MUE prevents payment.

Medicine Services CPT Code 90000-99999

CLEID 2.90000 - HCPCS/CPT procedure code definition

For example, the code descriptor for CPT code 96406 is “Chemotherapy administration; intralesional, more than 7 lesions,” and the code descriptor for CPT code 96405 is “Chemotherapy administration; intralesional, up to and including 7 lesions.” Based upon the code descriptors the procedure described by CPT code 96405 cannot be reported with CPT code 96406 since either more than 7 or 7 or fewer lesions are treated.

CLEID 3.90000 - CPT Manual or CMS manual coding instruction

For example, CPT instruction states for patients that require psychiatric services (90785-90899), adaptive behavior services (97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T) as well as health behavior assessment and intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171), report the predominant service performed. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 90785-90899 on the same date.

CLEID 4.90000 - Mutually exclusive procedures

For example, CPT codes 95710 (Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance) and 95709 (Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance) describe different types of EEG monitoring. Since both methods of EEG monitoring would not be used in the same 12-26 hour, the 2 procedures are mutually exclusive of one another.

CLEID 6.90000 - CPT “separate procedure” definition

For example, the code descriptor for CPT code 95851 (Range of motion measurements and report (separate procedure); each extremity . . .) includes the "separate procedure" designation. When a physical therapy evaluation (CPT codes 97161-97163) is performed, the procedure described by CPT code 95851 does not meet the definition of a “separate procedure.” Therefore,

CPT code 95851 cannot be reported separately.

CLEID 7.90000 - More extensive procedure

For example, CPT code 93010 describes the physician interpretation of an electrocardiogram (ECG). CPT code 93042 describes the physician interpretation of a cardiac rhythm strip. Since the ECG interpretation described by CPT code 93010 includes an interpretation of cardiac rhythm abnormalities, the procedure described by CPT code 93010 is more extensive than the procedure described by CPT code 93042.

CLEID 10.90000 - Standards of medical/surgical practice

For example, fluorescein angiography (CPT code 92235) requires the intravenous administration of fluorescein. Since intravenous insertion of a catheter (CPT code 36000) is a standard of medical/surgical practice to infuse the fluorescein, CPT code 36000 is bundled into CPT code 92235.

CLEID 11.90000 - Anesthesia service included in surgical procedure

For example, when an induction of arrhythmia by electrical pacing (CPT code 93618) is performed, anesthesia may be provided by the physician performing the procedure as described by CPT code 00410 (anesthesia for the electrical conversion of arrhythmias). Because anesthesia provided by the physician performing the procedure is not separately payable, CPT code 00410 is bundled into CPT code 93618 when the same physician performs both procedures.

CLEID 14.90000 - Misuse of Column Two code with Column One code

For example, CPT code 96912 describes photochemotherapy with psoralens and ultraviolet A light (PUVA). CPT code 77401 describes delivery of superficial radiation therapy. It is a misuse of CPT code 77401 to report it in addition to CPT code 96912 when PUVA therapy is administered.

CLEID 15.90000 - Medically Unlikely Edits, Units of Service

For example, CPT code 94002 describes all ventilation assist and management for the initial day of observation or inpatient hospital care. Therefore, CPT code 94002 may be reported with a maximum of one unit of service for a single date of service. If UOS in excess of one are reported, the MUE prevents payment.

CPT Category III Codes (0001T-0999T) (Temporary CPT Codes for Emerging Technology, Services, and Procedures)

CLEID 2.0000T - HCPCS/CPT procedure code definition

For example, CPT code 0054T describes a computer-assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on fluoroscopic images. CPT code 76000 describes fluoroscopy. Therefore, based upon the code descriptors the procedure described by CPT code 76000 is a component of the procedure described by CPT code 0054T.

CLEID 3.0000T - CPT Manual or CMS manual coding instruction

For example, the parenthetical note following CPT code 0201T (Percutaneous sacral augmentation (sacroplasty), bilateral injections . . .) states: “Do not report 0200T, 0201T in conjunction with 20225 when performed at the same level.” Therefore, CPT code 20225 (Biopsy, bone, trocar, or needle; deep. . .) may not be reported separately in addition to CPT codes 0200T or 0201T if the procedures are performed at the same level.

CLEID 4.0000T - Mutually exclusive procedures

For example, CPT codes 0101T and 0102T describe extracorporeal shock wave procedures involving different anatomic parts of the musculoskeletal system. CPT code 0101T describes extracorporeal shock wave involving an unspecified part of the musculoskeletal system and CPT code 0102T describes extracorporeal shock wave involving the lateral humeral epicondyle. Since both extracorporeal shock wave procedure codes should not be reported for the same patient at the same anatomic site, the 2 procedures are mutually exclusive of one another.

CLEID 6.0000T - CPT “separate procedure” definition

For example, the code descriptor for CPT code 49000 (Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)) includes the “separate procedure” designation. When a transluminal peripheral atherectomy of the abdominal aorta (CPT code 0236T) is performed, the procedure described by CPT code 49000 does not meet the definition of a “separate procedure.” Therefore, CPT code 49000 cannot be reported separately.

CLEID 7.0000T - More extensive procedure

For example, CPT code 0072T describes focused ultrasound ablation of uterine leiomyomata of a volume greater than or equal to 200 cc of tissue. CPT code 0071T describes focused ultrasound ablation of uterine leiomyomata of a volume less than 200 cc of tissue. The procedure described by CPT code 0072T is a more extensive procedure than CPT code 0071T.

CLEID 10.0000T - Standards of medical/surgical practice

For example, CPT code 0075T describes open or percutaneous transcatheter placement of extracranial vertebral artery stent(s). Since intravenous insertion of a catheter (CPT code 36000) is a standard of medical/surgical practice for this procedure, CPT code 36000 is bundled into CPT code 0075T.

CLEID 11.0000T - Anesthesia service included in surgical procedure

For example, if the physician performing a transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation of the abdominal aorta (CPT code 0236T) also provides anesthesia for the procedure, the anesthesia service is not separately reported. Therefore, CPT code 01926 (Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic) is bundled into CPT code 0236T.

CLEID 14.0000T - Misuse of Column Two code with Column One code

For example, CPT code 0075T describes open or percutaneous transcatheter placement of an extracranial vertebral artery stent in an initial vessel and includes radiologic supervision and interpretation. CPT code 77012 describes computed tomographic guidance for needle placement including radiologic supervision and interpretation. It is a misuse of CPT code 77012 to report radiologic guidance or supervision and interpretation for the procedure described by CPT code 0075T. Therefore, CPT code 77012 should not be reported with CPT code 0075T.

CLEID 15.0000T - Medically Unlikely Edits, Units of Service

For example, CPT code 0236T (Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta) may be reported with a maximum of one unit of service since there is only one abdominal aorta and an open or percutaneous transluminal peripheral atherectomy of this artery would not likely be performed more than once in a single day. If UOS in excess of one are reported, the MUE prevents payment.

HCPCS Level II Codes A0000-V9999

CLEID 2.A-V - HCPCS/CPT procedure code definition

For example, the code descriptor for HCPCS code G0398 is “Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation,” and the code descriptor for CPT code 93041 is “Rhythm ECG, 1-3 leads; tracing only without interpretation and report.” Based upon the code descriptors an ECG is a component of the home sleep study test.

CLEID 3.A-V - CPT Manual or CMS manual coding instruction

For example, the CPT Manual instruction above CPT code 49320 states: “Surgical laparoscopy always includes diagnostic laparoscopy. . .” Therefore, the surgical laparoscopic procedure described by the Column One HCPCS code G0342 (Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion) includes the diagnostic laparoscopic procedure described by the Column Two CPT code 49320 (Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)). Based on the CPT Manual instruction CPT code 49320 is bundled into HCPCS code G0342.

CLEID 4.A-V - Mutually exclusive procedures

For example, HCPCS code G0281 describes electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care, and HCPCS code G0283 describes electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care. Since both methods would not be performed at the same patient encounter, the 2 procedures are mutually exclusive of one another.

CLEID 6.A-V - CPT “separate procedure” definition

For example, the code descriptor for CPT code 49000 (Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)) includes the “separate procedure” designation. When a laparotomy for islet cell transplantation (HCPCS code G0343) is performed, the procedure described by CPT code 49000 does not meet the definition of a “separate procedure.” Therefore, CPT code 49000 may not be reported separately.

CLEID 7.A-V - More extensive procedure

For example, HCPCS code G0117 describes glaucoma screening performed by an ophthalmologist or optometrist. HCPCS code G0118 describes glaucoma screening performed under the direct supervision of an ophthalmologist or optometrist. Personal performance of a procedure is more extensive than direct supervision of a procedure, therefore, HCPCS code G0117 is a more extensive procedure than HCPCS code G0118.

CLEID 10.A-V - Standards of medical/surgical practice

For example, injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography (HCPCS code G0260) includes as a standard of medical/surgical practice all fluoroscopy (CPT code 76000) necessary to perform the procedure. Therefore, CPT code 76000 is bundled into HCPCS code G0260.

CLEID 11.A-V - Anesthesia service included in surgical procedure

For example, if the physician performing low dose rate (LDR) prostate brachytherapy (HCPCS code G0458) also provides anesthesia for the procedure, the anesthesia service is not separately reportable. Therefore, CPT code 00860 (anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified) is bundled into HCPCS code G0458.

CLEID 14.A-V - Misuse of Column Two code with Column One code

HCPCS code G0259 describes an injection procedure for arthrography of the sacroiliac joint. CPT code 27096 describes an injection procedure of an anesthetic/steroid for arthrography of the sacroiliac joint. It is a misuse of CPT code 27096 to report it with HCPCS code G0259 for a procedure on the same sacroiliac joint at the same patient encounter.

CLEID 15.A-V - Medically Unlikely Edits, Units of Service

For example, since HCPCS code G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) describes a screening test procedure that can only be performed once every 10 years, a maximum of 1 unit of service may be reported once on a single date of service. If UOS in excess of one are reported, the MUE prevents payment.

Examples of Deleted National Correct Coding Initiative (NCCI) PTP Edits and MUEs

CLEID 13.DELETEPR4 - Deleted NCCI PTP Edit Example

For example, the edit with Column One CPT code 93621 and Column Two CPT code 93620 was deleted because the 2002 CPT Manual added a reference note following CPT code 93621 which stated: “Use 93621 in conjunction with 93620.” Therefore, based upon new CPT Manual coding instructions, the edit was deleted.

CLEID 16.DELETEPR5 - Deleted MUE Example

For example, the MUE criterion for CPT code 49200 (Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas) was implemented as “1” on January 1, 2007. Since this code was deleted from the CPT Manual on January 1, 2008, the MUE for the code was deleted December 31, 2007.

Acronyms

CLEID	Correspondence Language Example Identification Number
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPAC	Health Care Professionals Advisory Committee
HCPCS	Healthcare Common Procedure Coding System
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NHO	National Healthcare Organization
OPPS	Hospital Outpatient Prospective Payment System
PTP	Procedure-to-Procedure
RS&I	Radiological Supervision and Interpretation
UOS	Units of Service