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



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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. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

## C. 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 one 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 one 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. CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. If a provider reports CPT code 64721, he cannot additionally report CPT code 29848 for the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

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 one procedure are included in the column one 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 Carriers' Manual* Section 15055 (*Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 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.

13. CPT code 61623 (endovascular temporary balloon arterial occlusion … concomitant neurological monitoring, …) describes a procedure that includes prolonged neurologic assessment. This code should not be utilized to report the temporary arterial occlusion that is an inherent component of CPT code 61624 (transcatheter permanent occlusion or embolization …; central nervous system (intracranial, spinal cord)).

14. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1, 2005 through December 31, 2005, CMS allowed CPT code 95870 to be reported for such guidance when medically reasonable and necessary. Effective January 1, 2006, needle EMG guidance for muscle chemodenervation procedures coded as CPT codes 64612-64614 may be reported with CPT code 95874.

15. Some procedures (e.g., intracranial, spinal) utilize intraoperative neurophysiology testing. 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 (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

**D. 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.

**E. 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.

**F. Operating Microscope**

1. CMS allows payment for use of the operating microscope (CPT 69990) with a list of procedures identified in the *Internet-Only Manuals(IOM) Medicare Claims Processing Manual* (Publication 100-04), Chapter 12, Section 20.4.5 (Allowable Adjustments) (formerly *Medicare Carriers' Manual*, Section 15055). NCCI bundles CPT code 69990 into all other surgical procedures. Most edits do not allow use of NCCI-associated modifiers.

**G. General Policy Statements**

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the 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 drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these

codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

4. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

5. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.