Coding Policy

Procedure-Specific Policies

CODING POLICY NUMBER: 4

Effective Date: 1/1/2024

Last Review Date: 1/2024

Next Annual Review: 2025

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Company applies National Correct Coding Initiative procedure-to-procedure edits (CCI edits) as published by the Centers for Medicare and Medicaid Services (CMS).

II. Company applies additional procedure-to-procedure edits which are based on standards for clinical care, CMS coding guidelines, National Correct Coding Initiative Policy Manual, American Medical Association (AMA) coding guidelines, and/or specialty society coding guidelines. *(See the Procedure section below for these supplemental procedure-to-procedure edits applied by the plan.)*

PROCEDURE

BACKGROUND

In addition to applying general National Correct Coding Initiative procedure-to-procedure edits (CCI edits) as published by the Centers for Medicare and Medicaid Services (CMS), Company also uses standards for clinical care, CMS coding guidelines, National Correct Coding Initiative Policy Manual, AMA coding guidelines, and/or specialty society coding guidelines to develop the following supplemental procedure-to-procedure edits.

Table 1: 04.0.01

Removal of Intrauterine Device (58301) Denied When Billed with Evaluation and Management Services (99202-99215 or 99381-99397)		
Codes	58301	Removal of intrauterine device (IUD)
	99202-99215	Illness-related E/M services
	99381-99397	Preventive E/M services
Effective Date	8/2001	
Policy	Company does not pay separately for removal of an intrauterine device (IUD) (CPT code 58301) when billed with preventive evaluation and management (E/M) services. Company has determined that removal of an IUD involves minimal time and resources, is incidental to the pelvic examination performed as part of the preventive E/M service for women and does not warrant separate reimbursement. Company may pay for removal of an IUD with an illness-related E/M visit if review of chart notes shows the patient did not present solely for IUD removal and there is a significant, separately identifiable E/M visit documented. If the patient presents solely for IUD removal, and no significant, separately identifiable E/M visit is documented, CPT code 58301 should be billed without an E/M code. If a pelvic examination is required for the presenting problem, IUD removal is considered incidental to the pelvic exam and is not paid separately.	

Table 2: 04.0.02

Negative Pressure Wound Therapy (97605-97606) Denied When Billed With Debridement Codes (11042-11047)		
Codes	97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
	97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
	11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
	11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
	11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
Effective Date	7/2005	
Policy	Negative pressure wound therapy is inherent to surgical debridement when performed at the same site at the same surgical encounter and is not reimbursed separately. CPT codes 97605 and 97606 will deny when billed with CPT codes 11042-11047.	

Table 3: 04.0.03

Tympanolysis (69450) Denied When Billed With Tympanoplasty (69631-69646)		
Codes	69450	Tympanolysis, transcanal
	69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
	69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)
	69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])
	69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
	69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
	69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])

	69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
	69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
	69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
	69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
Effective Date	8/2007	
Policy	National Correct Coding Initiative Policy Guidelines state that lysis of adhesions is considered incidental to other procedures performed in the same anatomic area. Based on this rationale, CPT code 69450 is denied when billed with CPT codes 69631-69646. The denial will be overturned on appeal if the operative note shows tympanolysis was performed on the opposite ear from CPT codes 69631-69646.	

Table 4: 04.0.04

Needle Electromyography (95867) Denied When Billed With Tympanoplasty (69631-69646)		
Codes	95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral
	69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
	69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)
	69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])
	69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
	69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
	69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with

		ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])
	69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
	69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
	69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
	69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
Effective Date	8/2007	
Policy	National Correct Coding Initiative Policy Guidelines state, "Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) shall not be reported by the physician performing an operative procedure since it is included in the global package. The physician performing an operative procedure shall not bill other 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, **95867**, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package." Monitoring of the facial nerve during tympanoplasty is included in payment for tympanoplasty and may not be billed separately.	

Table 5: 04.0.05

Laryngoscopy (31505) Denied When Billed With Evaluation and Management Codes (99202-99499)		
Codes	31505	Laryngoscopy, indirect; diagnostic (separate procedure)
	99202-99499	E/M Services
Effective Date	9/2003	
Policy	Company does not pay separately for diagnostic indirect laryngoscopy (CPT code 31505) with Evaluation and Management Services. Company has determined that this service is used to enhance the typical examination of the area and does not require significant additional resource utilization. Company considers this incidental to the Evaluation and Management service.	

Table 6: 04.0.06

Interpretation and Report of ECG Rhythm Strip, 1-3 Leads (93042) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	93042	Rhythm ECG, one to three leads; interpretation and report
	99202-99499	E/M Services
Effective Date	2/2006	
Policy	Company does not pay separately for the interpretation and report of ECG rhythm strips (CPT code 93042) with E/M services. Company has determined that interpretation and report of a 1-3 lead ECG rhythm strip is generally performed as a routine part of the evaluation of the patient and is integral to the data review element of the medical decision making component of an E/M service and does not involve enough significant additional resources to warrant separate reimbursement.	

Table 7: 04.0.07

Interpretation and Report of 12-Lead Routine Electrocardiogram (93010) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
	99202-99499	E/M Services
Effective Date	3/2007	
Policy	Interpretation and report of 12-lead routine electrocardiogram (ECG) is considered an integral part of Evaluation and Management (E/M) services and will not be paid separately. The performance of an ECG and obtaining the "tracing only" during an office visit represents a diagnostic study that is separately reportable, as the provider is utilizing their own office equipment and thus incurring the cost of performing the electrocardiogram. However, the "interpretation and report only" of an ECG by the provider in an office is a component of the E/M service. By the same token, a review of ECG is commonly performed by physicians in the hospital and emergency room as a routine part of evaluation of the patient. Both office and hospital E/M services include reviewing results of diagnostic studies. Thus, the "interpretation and report only" of an electrocardiogram is considered an integral component of an E/M service in the office or in a facility and does not warrant separate reimbursement.	

Table 8: 04.0.08

Colonoscopy with Injection (45381) Denied When Billed With Colonoscopy Codes (45380, 45384, 45385, and 45388)		
Codes	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
	45380	Colonoscopy, flexible; with biopsy, single or multiple
	45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

	45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
Effective Date	1/2004	
Policy	CPT code 45381 is used to report a procedure in which the physician performs flexible colonoscopy proximal to the splenic flexure and injects a substance into the submucosa, directed at specific areas through the scope while viewing the colon. Submucosal saline injections may be done before polypectomy using snare and electrocautery to enhance the effectiveness of resection for large sessile colorectal polyps. India dye injection may be performed either before or after lesion removal or biopsy. Company has determined that injection of saline prior to polypectomy is preparatory in nature, represents the standard of care in accomplishing the overall procedure, and takes minimal additional time and resources. India dye injection either before or after lesion removal or biopsy takes minimal additional time and resources. Both of these procedures are considered incidental to the other more intense services performed when performed at the same anatomic location (same lesion) during the same patient encounter.	

Table 9: 04.0.09

Anoscopy (46600) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
	99202-99499	E/M Services
Effective Date	3/2010	
Policy	Company has determined that anoscopy at the time of an E/M service does not involve extensive use of time and/or resources and is considered an integral component of the E/M service. When a patient presents with problems of the anus and rectal area, a digital rectal examination is indicated. Company has determined that performing anoscopy at the time of a digital rectal exam is equivalent to the use of a speculum when performing a pelvic examination and should not be billed as a separate procedure. When CPT code 46600 is billed with an E/M code, only the E/M code will be reimbursed. Modifier -25 on the E/M code will not bypass this edit. CPT code 46600 may be paid when it is the only service billed.	

Table 10: 04.0.10

Demonstration/Evaluation of Patient Utilization of Nebulizer, Inhaler, or IPPB Device (94664) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
	99202-99499	E/M Services

Effective Date	12/2004
Policy	Company does not pay separately for demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (CPT code 94664) with an E/M service based upon CPT guidelines for E/M services, which include "...instructions for management (treatment)..." as an element of the counseling component of E/M services. Instructing a patient on the proper use of a medication is considered part of the overall management of the patient. Reporting both procedure codes on the same day represents an overlap of services and separate reimbursement is not warranted. Company agrees with National Correct Coding Initiative (NCCI) guidelines, which state, "Evaluation and Management services, in general, are cognitive services and significant procedural services are not included in the Evaluation and Management services; certain procedural services that arise directly from the evaluation and management service are included as part of the Evaluation and Management service. Cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, counseling and educational services, among other services are included in evaluation and management services." Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device is considered a counseling and education service, which is included in E/M services.

Table 11: 04.0.11

Urinalysis, Dip Stick (81002-81003) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
	81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
	99202-99499	E/M Services
Effective Date	6/2005	
Policy	Company does not pay separately for urinalysis, dip stick, without microscopy (81002-81003) with an E/M service. Company has determined that urinalysis, dip stick, without microscopy is an incidental service which is routinely performed in the course of an E/M service. Urinalysis, dip stick, without microscopy does not represent significant additional work and resources and arises directly from the E/M service and is therefore considered to be part of the E/M service.	

Table 12: 04.0.12

Binocular Microscopy (92504) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	92504	Binocular microscopy (separate diagnostic procedure)

	99202-99499	E/M Services
Effective Date	1/2006	
Policy	Company does not pay separately for binocular microscopy (CPT code 92504) with E/M services. Company has determined that this procedure does not accomplish significantly more than a standard medical examination of the ear and is considered integral to the exam conducted during an E/M service, and as such does not warrant additional reimbursement.	

Table 13: 04.0.13

Canalith Repositioning Maneuvers (95992) Denied When Billed With Evaluation and Management Services (99202-99499)		
Codes	95992	Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
	99202-99499	E/M Services
Effective Date	6/2012	
Policy	Company has determined that canalith repositioning maneuver does not add significant time and intensity to an E/M service and should not be reported in conjunction with an E/M code. However, the code may be paid if it is the only service performed.	

Table 14: 04.0.14

Lumbar Laminectomy (63005, 63012, 63017, 63030, 63042, and 63047 and Associated Add-on Codes) Denied When Billed With Arthrodesis (22630 and 22633)		
Codes	63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
	63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
	63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar
	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
	63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
	22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
Effective Date	6/2004	
Policy	Company does not allow lumbar laminectomy codes (63005, 63012, 63017, 63030, 63042, or 63047 or add-on codes associated with each of these codes) to be reported with lumbar arthrodesis codes (22630, 22632, 22633, and 22634) when performed at the same level of the spine. Company has determined that whenever arthrodesis is performed, decompression is inherently carried out as well. During the arthrodesis, a laminectomy is done which necessarily decompresses the nerve roots and dural sac. In addition, diskectomy decompresses the nerve roots and dural sac, even if the disc is herniated. Thus, performance of laminectomy, facetectomy, foraminotomy, discectomy, or decompression is considered clinically integral to the primary arthrodesis procedure when performed at the same anatomic site, i.e. same level of the spine.	

Table 15: 04.0.15

Operating Microscopy (69990) Denied When Billed With Procedures Not Listed		
Codes	69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)
Effective Date	9/2005	
Policy	Company follows guidelines in the Medicare Claims Processing Manual, Chapter 12, which allows separate payment for CPT code 69990 only with the following codes: • 61304 through 61546 • 61550 through 61711 • 62010 through 62100 • 63081 through 63308 • 63704 through 63710 • 64831 • 64834 through 64836 • 64840 through 64858 • 64861 through 64871 • 64885 through 64891 • 64905 through 64907	

Table 16: 04.0.16

CPT Codes 63020-63030 or 63040-63042 Denied When Billed With CPT Codes 63045-63047 for Contiguous Levels of Spine		
Codes	63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
	63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
	63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical
	63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
Effective Date	7/2018	
Policy	Company does not pay CPT codes 63020-63030 or 63040-63042 when billed with CPT codes 63045-63047 for procedures performed at contiguous levels of the spine. When discectomy is performed with laminectomy for stenosis, the discectomy is included in payment for the laminectomy. When decompression is performed for stenosis at multiple contiguous levels of the spine with disc herniation at one or more of the levels, CPT code 63045 or 63047 may be reported for the initial level treated, and CPT code 63046 or 63048 may be reported for the additional level(s) of the spine treated.	

Table 17: 04.0.17

Hearing and Vision Screening (CPT Codes 99173, 99174, 99177, 92551, 92583)		
Codes	99173	Screening test of visual acuity, quantitative, bilateral
	99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report
	99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis
	92551	Screening test, pure tone, air only
	92583	Select picture audiometry
Effective Date	1/2016	
Policy	Company will allow CPT codes 99173 and 92551 when billed with preventive visits (CPT codes 99381-99397). The member's benefit for preventive services will apply. Documentation for 92551 must show that pure tone audiometry was performed and not simply whispered voice or tuning fork. CPT guidelines state that hearing screening performed by whispered voice or tuning fork is included in payment for the Evaluation and Management service and may not be billed separately. CPT codes 99173 and 92551 will be considered incidental to illness-related visits (CPT codes 99202-99215) because a diagnostic eye exam or hearing exam is included in the medical decision-making component of an illness-related visit.	

	CPT codes 99174 (Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report), and 99177 (Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis) will be paid for vision screening with the following limitations: •Paid once every 12 months for children between the ages of 9 months and 3 years of age. •Must be billed as part of a preventive service (CPT codes 99381-99382 and 99391-99392). CPT code 92583 (Select picture audiometry) is not considered routine screening and will not be covered unless the documentation shows medical indications for more extensive testing. When more extensive testing is required, providers may submit an appeal with medical records showing the necessity for more extensive testing.

Table 18: 04.0.18

Problem-Related Evaluation and Management Services Denied When Billed With Preventive Evaluation and Management Services		
Codes	99202-99215	Problem-related E/M services
	99381-99397	Preventive E/M services
	G0438-G0439	Preventive medicine E/M services (known as Wellness Visits) for Medicare Advantage patients
Effective Date	1/2006 (updated 2/2023)	
Policy	The examination for an annual physical is comprehensive and includes all body areas and organ systems. When a provider encounters signs and/or symptoms that significantly alter the history, exam and medical decision making that would have been performed as part of a routine preventive service, the visit is generally an illness-related or problem-related visit, and the appropriate level of problem-related E/M code (CPT codes 99202-99205, 99211-99215) should be billed rather than the preventive service code. Providers may appeal these denials with chart notes. Denials will be overturned only if the documentation shows a significant, separately identifiable E/M service was performed with the preventive E/M service. Effective for dates of service on or after 2/1/2023, when a significant, separately identifiable problem-related E/M service is performed on the same day as a preventive E/M service for patients **under the age of 18**, the E/M code for an established patient (99212-99215) may be reported with the preventive service. Modifier 25 and modifier 52 must both be appended to the problem-related E/M code to allow it to be paid with the preventive services E/M code. The problem-related E/M code (99212-99215) will be paid at 50% of the usual allowable for that service. See Coding Policy 52.0 (Medical Visits) for details.	

Table 19: 04.0.19

Multiple Units of Dosimetry Calculations (CPT Code 77300), Treatment Devices (CPT Codes 77332-77334), and Multi-Leaf Collimator (MLC) Devices for IMRT (CPT Code 77338) for Radiation Oncology		
Codes	77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
	77332	Treatment devices, design and construction; simple (simple block, simple bolus)
	77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
	77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
	77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
Effective Date	4/2010	
Policy	**Basic Radiation Dosimetry Calculation** (**CPT Code 77300**) This service is considered to be medically necessary for each treatment port (gantry angle for IMRT) and if a patient has off-axis calculations, calculations for different depth doses, different volumes of interest, secondary film dosimetry, abutting volumes of interest, or any other situation requiring individual point calculations of radiation dosage. Changes in a patient's weight or girth during the course of radiation treatment may necessitate dosimetry recalculation. Company will pay one unit of code 77300 per treatment port (per gantry angle for IMRT) per course of therapy, with additional calculations allowed if medically indicated, to a maximum of ten units (combined for all ports or gantry angles) per day, and a maximum of twenty units total (combined for all ports or gantry angles) per course of therapy. Code 77300 **may be reported only when the plan is verified**. The documentation must show the date of verification and **must be signed** by the provider who performed the verification. **The date of service is the date the plan is verified.** **Treatment Device Design and Construction (CPT Codes 77332-77334)** Many different types of treatment devices are used in the successful delivery of radiation oncology treatments. Examples include beam-shaping devices, custom-fabricated patient-immobilization devices, beam-modification devices, and equipment used to shield critical structures. Their use is determined by the clinical judgment of the radiation oncologist based on patient anatomy and disease state. They are fabricated as the direct result of physician work and supervision. During the course of fractionated radiation therapy, the accuracy of their daily use is the direct responsibility of the treating physician. When charging for devices, the physician is charging for the design of custom blocks, and the facility is charging for the construction of those blocks. Payment for one set of devices (one of the three CPT	

	codes listed above) will be allowed for each port (per gantry angle for IMRT). A pair of devices for opposing ports (e.g., left and right lateral, AP and PA) constructed from a single film is considered one port for billing purposes. However, if each member of the pair requires a separate film for its construction (two films used), then one PC (professional component) and two TC (technical components) are billed separately. An individual treatment device may be reported and charged only one time for the entire course of treatment, regardless of the number of times the device is used. **The date of service is the plan print date.** When the patient has a combination of a wedge, a compensator, a bolus or a port block covering the same treatment port, this would be billed as a single complex treatment device rather than a separate charge for each of the individual items. In all levels of complexity, the physician must be directly involved in the design, selection and placement of any of the devices. Products used for patient comfort (e.g., pillows, pads, cushions) should not be charged as treatment devices. Company will pay one unit of code 77332, 77333, or 77334 per treatment port (per gantry angle for IMRT) per course of therapy (with additional units allowed if the documentation shows the size of the lesion has changed significantly, the patient is repositioned, patient body habitus has changed, a different volume of interest is treated, or a boost is performed) **to a maximum of ten units total (combined for all ports) per course of therapy.** **MLC Devices for IMRT (CPT Code 77338)** Multi-leaf collimator (MLC) device(s) (CPT code 77338) may be reported only once per IMRT plan. If a patient receiving IMRT requires an additional treatment device due to change in tumor volume or change in patient's weight, this device may be reported with the appropriate code from the range of CPT codes 77332-77334. Company would not expect to see additional billing of CPT code 77338 for the same IMRT plan unless an exceptional circumstance should arise; for example, if the beneficiary was in a car accident after the device was designed, and as a result, suffered injuries that impacted the construction of the device, a subsequent billing of CPT 77338 could be appropriate for the same treatment plan. If this, or any other situation were to occur, Company expects to see it thoroughly documented in the medical record to support the medical necessity of a second occurrence of CPT 77338. Under no circumstances will PHP pay for more than two units of CPT code 77338 per IMRT plan.

Table 20: 04.0.20

Exploration of Spinal Fusion (22830) Denied When Billed With Related Spine Surgeries		
Codes	22830	Exploration of spinal fusion
Effective Date	4/2006	
Policy	CPT code 22830 will not be reimbursed when performed in the same surgical field as another spine surgery.	

	Company follows National Correct Coding Initiative (NCCI) Policy Manual guidelines for CPT code 22830, which state: "Exploration of the surgical field is a standard surgical practice. Physicians shall not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 shall not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59 or XS."

Table 21: 04.0.21

Open Treatment of Femoral Fracture, Medial or Lateral Condyle (27514) Denied When Billed With Open Treatment of Supracondylar or Transcondylar Femoral Fracture (27513)		
Codes	27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
	27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
Effective Date	2/2007	
Policy	Fracture treatment represented by these two codes may involve a duplication of work depending on the locations of the fractures involved. Medical record review is necessary to determine if two separate and distinct fracture reduction procedures have been performed.	

Table 22: 04.0.22

Arthroscopic Removal of Loose Body or Foreign Body From Hip (29861) Denied When Billed With Arthroscopic Chondroplasty of Hip (29862) or Arthroscopic Synovectomy of Hip (29863)		
Codes	29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
	29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
	29863	Arthroscopy, hip, surgical; with synovectomy
Effective Date	3/2012	
Policy	Arthroscopic removal of loose body or foreign body from the hip may be paid with other procedures on the ipsilateral hip only if the loose or foreign body is 5 millimeters or greater in diameter or is removed through a separate incision/portal. This logic is supported coding guidelines in "CPT® Assistant," December, 2020, Volume 30, Issue 12 , which states: "Arthroscopic removal of loose body(ies) or foreign body(ies) (ie, 29819, 29834, **29861**, 29874, 29894, 29904) may be reported only when the loose body(ies) or foreign body(ies) is equal to or larger than the diameter of the arthroscopic cannula(s) used for the specific procedure, and can only be removed through a cannula larger than that used for the specific procedure or through a separate incision or through a portal that has been enlarged to allow removal of the loose or foreign body(ies)."	

Table 23: 04.0.23

Laryngoscopy With Injection to Vocal Cords (31570) Denied When Billed With Laryngoscopy With Dilation (31528)		
Codes	31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
	31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial
Effective Date	6/2006	
Policy	Company has found that providers use CPT code 31570 to report steroid injections performed at the site of dilation (CPT code 31528). Review of documentation for these cases does not show injection into the vocal cord(s) for therapeutic purposes to support use of CPT code 31570. Steroid injections at the site of dilation are incidental to the dilation procedure and may not be reimbursed separately. If review of medical records shows appropriate use of CPT code 31570, both procedures may be paid.	

Table 24: 04.0.24

Endocervical Curettage (57505) Denied When Billed With Colposcopy of the Cervix (57461)		
Codes	57505	Endocervical curettage (not done as part of a dilation and curettage)
	57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
Effective Date	6/2005	
Policy	Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure. CPT code 57461 includes excision of endocervix when necessary, so endocervical curettage (57505) is considered an integral component of 57461 and may not be billed separately.	

Table 25: 04.0.25

Removal of IUD (58301) Denied When Billed With Endometrial/Endocervical Sampling/Biopsy (58100)		
Codes	58301	Removal of intrauterine device (IUD)
	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
Effective Date	6/2006	
Policy	Removal of IUD at the time of a related procedure does not involve significant additional resources or time and is therefore considered incidental to the primary procedure.	

Table 26: 04.0.26

Chromotubation of Oviduct (58350) Denied When Billed With Surgical Hysteroscopy (58558)		
Codes	58350	Chromotubation of oviduct, including materials
	58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
Effective Date	4/2006	

Policy	Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure. When chromotubation is performed following another procedure to verify patency of tubes, it is integral to the success of the other procedure and is therefore considered incidental to the primary procedure. This rationale is supported by guidance from the AMA in the May, 2002, issue of "CPT Assistant," which states that chromotubation of oviduct that is performed following another procedure to determine if the tube is patent following the primary procedure, it is considered an integral component of the overall procedure.

Table 27: 04.0.27

Parathyroid Autotransplantation (60512) Denied When Billed With Parathyroidectomy (60500)		
Codes	60512	Parathyroid autotransplantation (List separately in addition to code for primary procedure)
	60500	Parathyroidectomy or exploration of parathyroid(s)
Effective Date	4/2014	
Policy	CPT code 60512 is an add-on code, and CPT instructions say to use this code in conjunction with CPT code 60500. CPT code 60512 is used to report excision and reimplantation of parathyroid tissue. This procedure may be performed if a thyroidectomy has resulted in damage to the viability of the parathyroid glands, or if a parathyroidectomy has been performed for parathyroid disease. The remaining tissue is implanted in the area of the sternocleidomastoid or forearm muscle, which makes the parathyroid tissue easily accessible and reduces the risk of needing another operation in the neck area. Company has found that surgeons are using CPT code 60512 when they simply drop a piece of parathyroid tissue into the cavity following parathyroidectomy. This does not constitute a separate procedure to justify reporting CPT code 60512. Company will allow CPT code 60512 to be paid with CPT code 60500 when review of the operative note shows a separate incision for transplantation of parathyroid tissue in the sternocleidomastoid or forearm muscle. Company does not allow separate payment for CPT code 60512 when pieces of parathyroid tissue are simply dropped into the cavity following parathyroidectomy.	

Table 28: 04.0.28

Esophagoscopy With Biopsy (43202) and Esophagogastroduodenoscopy With Biopsy (43239) Denied When Billed With Diagnostic ERCP (43260) and Therapeutic ERCP (43261-43265 and 43274-43278)		
Codes	43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple
	43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple

	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
	43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
	43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
	43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi
	43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)
	43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)
	43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)
	43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged
	43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct
	43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed
Effective Date	4/2017	
Policy	Endoscopy coding guidelines from the National Correct Coding Initiative (NCCI) policy manual, "Digestive System Endoscopy" section, include the following instructions: 1. When a diagnostic endoscopy is performed in conjunction with endoscopic therapeutic services, the appropriate CPT code to use is the most comprehensive endoscopy code describing the service performed. If the same therapeutic endoscopy service is performed repeatedly (e.g. polyp removal) in the same area described by the CPT narrative, only one CPT code is reported with one unit of service. If different therapeutic services are performed and are not adequately described by a more comprehensive CPT code, the appropriate codes can be designated in accordance with the multiple GI endoscopy rules previously established by CMS. 2. When a diagnostic endoscopy is followed by a surgical endoscopy, the diagnostic endoscopy is considered part of the surgical endoscopy (per CPT definition) and is not to be separately reported.	

	3. Only the more extensive endoscopic procedure is reported for a session. For example if a sigmoidoscopy is completed and the physician performs a colonoscopy during the same session only the colonoscopy, is coded. It is, however, acceptable to bill for multiple services provided during an endoscopic procedure (with the exception of treating bleeding induced by the procedure); these services would be reimbursed under the multiple endoscopic payment rules for gastrointestinal endoscopy." Because the scope is passed through the esophagus, stomach, and into the duodenum during ERCP, diagnostic endoscopy of the esophagus, stomach, and/or duodenum is incidental to the more extensive ECRP procedure and may not be reported separately based on the NCCI policy.

Table 29: 04.0.29

Electronic Health Record Assessment and Management Consultation (99451) Denied When Billed Within 30 Days of E/M Services or Procedures		
Codes	99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
	99202-99499	E/M Services
	10000-69999	Medical Procedures
Effective Date	11/2020	
Policy	CPT guidelines for CPT code 99451 state: "The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported." Because the "next available appointment" for specialists is usually at least 30 days, Company has configured this edit to deny CPT code 99451 if an E&M code or other service is billed by the same provider either on the same day as CPT code 99451 or 14 days before 99451 or 30 days after CPT code 99451.	

Table 30: 04.0.30

Control Anterior Nasal Hemorrhage (30901) Denied When Billed With E/M Services (99202-99499)		
Codes	30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

	99202-99499	E/M Services
Effective Date	9/2017	
Policy	"CPT Assistant," July, 2020, states: "…code 30901 is reported when limited cautery and/or packing is performed to serve a hemostatic and/or tamponading role, above and beyond an E/M service. In other words, if the bleeding site was identified, the physician cauterized the site and limited packing was left at the end of the encounter (absorbable or non-absorbable) to act in a more prolonged hemostatic fashion, rather than simply applying topical agents to the nose (whether by spray or in a very temporary manner via cotton applicator, cottonoid, etc), then code 30901 should be reported. Note that the simple placement of a pack that does not remain after the physician encounter is completed does not constitute reporting code 30901." Company finds that CPT code 30901 is used when simple cautery with silver nitrate is performed and/or temporary packing is placed. These services do not require extensive use of time or resources and are considered a component of the E/M service. CPT code 30901 may be paid separately from the E/M service on appeal if review of the documentation shows significant time and resources were required and criteria outlined by the AMA in the "CPT Assistant" article above are met.	

Table 31: 04.0.31

Cerumen Removal (69209 and 69210) Denied When Billed with E/M Services (99202-99499)		
Codes	69209	Removal impacted cerumen using irrigation/lavage, unilateral
	69210	Removal impacted cerumen requiring instrumentation, unilateral
	99202-99499 G0438-G0439	E/M Services
Effective Date	1/2016	
Policy	Company does not cover simple, non-impacted cerumen removal or removal of impacted cerumen using irrigation/lavage (CPT code 69209) when billed with an E/M service. This work is included in E/M services and should not be reported separately. CPT code 69210 may NOT be used to report cerumen removal by irrigation/lavage. CPT code 69210 may be reported when instruments are utilized to remove impacted cerumen. In this context, instrumentation is defined as the use of an otoscope and other instruments such as wax curettes, wire loops, or suction plus specific ear instruments (e.g., cup forceps, right angle hook). Company may pay separately for CPT code 69210 with E/M services on appeal if the documentation shows complicated cerumen removal performed by MD or physician extender (NP, PA) that adds significant time and intensity to the E/M service.	

Table 32: 04.0.32

Nasal Endoscopy With Debridement (31237) Denied When Billed with E/M Services (99202-99499)		
Codes	31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

	99202-99499	E/M Services
Effective Date	5/2013	
Policy	When debridement is performed to removal nasal crusts following functional endoscopic sinus surgery (FESS), Company will allow either an E&M code (CPT codes 99212-99215) or the debridement code (CPT code 31237) to be reported, but not both codes. If CPT code 31237 is reported, Company expects the documentation to support the procedure as described in PHP Coding Policy 58.0 (Documentation Guidelines for Medical Services). Functional Endoscopic Sinus Surgery Codes: • 31240: Nasal/sinus endoscopy, surgical; with concha bullosa resection • 31253: Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed • 31254: Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior) • 31255: Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior) • 31256: Nasal/sinus endoscopy, surgical, with maxillary antrostomy • 31257: Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy • 31259: Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus • 31267: Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus • 31276: Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus • 31287: Nasal/sinus endoscopy, surgical, with sphenoidotomy • 31288: Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus If the E/M service is not related to post-operative care following FESS but is for a different diagnosis, the provider may submit an appeal with medical records for review.	

Table 33: 04.0.33

Ovarian cystectomy (58925) Denied When Billed With Oophorectomy (58940)		
Codes	58925	Ovarian cystectomy, unilateral or bilateral
	58940	Oophorectomy, partial or total, unilateral or bilateral
Effective Date	8/2006	
Policy	CPT code 58940 is used to report a procedure to remove part or all of one or both ovaries. This is an open surgical procedure requiring exposure of the uterus and ovaries via an incision into the abdominal cavity.	

	CPT code 58925 is used to report an ovarian cystectomy that is performed through a small, lower abdominal incision. The affected ovary is visualized and the cyst is then removed. CPT codes include verbiage such as simple/complex, limited/complete, superficial/deep, partial/total in several of their procedure descriptions. When similar or identical procedures are performed, but are qualified by an increased level of complexity, only the definitive, or most comprehensive, service performed should be reported. This logic is supported by the CMS guideline for More Extensive Procedure found in the National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I, which states, "...the less extensive procedure is included in the more extensive procedure." When performed on the same side, removal of ovarian cysts is incidental to the removal of the ovary, and CPT code 58925 may not be paid separately. Separate payment may be warranted for both codes when the two procedures are performed on opposite sides.

Table 34: 04.0.34

Elective Cardioversion (92960) Denied When Billed in Emergency Department		
Codes	92960	Cardioversion, elective, electrical conversion of arrhythmia; external
Effective Date	4/2023	
Policy	Company does not pay CPT code 92960 when performed in the Emergency Department (Place of Service 23). Company follows National Correct Coding Initiative (NCCI) Policy Manual guidelines for CPT code 92960, which state: “There is no CPT code to report emergency cardiac defibrillation. It is included in cardiopulmonary resuscitation (CPT code 92950). If emergency cardiac defibrillation without cardiopulmonary resuscitation is performed in the emergency department or critical/intensive care unit, the cardiac defibrillation service is not separately reportable.” CPT code 92960 is used to report a procedure that is scheduled in advance. It is not appropriate to bill this code for cardioversion performed on an emergent basis in the Emergency Department.	

Table 35: 04.0.35

Health and Wellness Coaching (0591T-0593T) Considered Inclusive to E/M Service		
Codes	0591T	Health and well-being coaching face-to-face; individual, initial assessment
	0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes
	0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes
	99202-99499	E/M Codes
Effective Date	9/2023	

Policy	Payment for CPT codes 0591T, 0592T, and 0593T (health and well-being coaching) is included in payment for E/M services. Providers performing these services may bill using the appropriate E/M code supported by the documentation. If billed with an E/M code, CPT codes 0591T-0593T will deny as bundled to the E/M code. If billed without an E/M code, CPT codes 0591T-0593T will deny with the message "Rebill with Alternate Code." Providers who are credentialed with PHP and who may perform E/M services may submit a corrected claim to report the E/M code supported by the documentation. Codes 0591T-0593T are not payable when performed by providers who are not credentialed with PHP or by providers who may not report E/M services.

Table 36: 04.0.36

HCPCS Code G2211 (Add-On Code) Denied if 99202-99205 or 99211-99215 Billed with Modifier 25		
Codes	G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
	99202-99205	Office or other outpatient visit for the evaluation and management of a new patient
	99211-99215	Office or other outpatient visit for the evaluation and management of an established patient
Effective Date	1/2024	
Policy	HCPCS code G2211 (E/M complexity add-on code) is not paid when the associated E/M visit (CPT code 99202-99205 or 99211-99215) is billed with modifier 25 for the same patient by the same practitioner. Separately identifiable visits occurring on the same day as minor procedures, such as zero-day global procedures, have resources sufficiently distinct from the costs associated with providing stand-alone E/M visits to justify different payment.	

REFERENCES

None

POLICY REVISION HISTORY

Date	Revision Summary
4/2023	Annual review (converted to new template 5/2023). Original policy effective date: 1/2022
6/2023	Added Policy 04.0.35, effective 9/1/2023.

1/2024	Annual review. Added Policy 04.0.36 for G2211, effective 1/1/2024.
3/2024	Added HCPCS codes G0438-G0439 to Table 31 for clarification. The edit is set up to deny CPT codes 69209 and 69210 with all E/M codes, including G0438-G0439, but those codes weren't identified in the policy.