Coding Policy

Procedure-Specific Policies

CODING POLICY NUMBER: 4

Effective Date: 4/1/2026

Last Review Date: 12/2025

Next Annual Review: 2026

POLICY STATEMENT **1**

PROCEDURE **2**

CROSS REFERENCES **22**

REFERENCES **22**

POLICY REVISION HISTORY **22**

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

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

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 supplemental procedure-to-procedure edits - see Coding Policy 01.0 (General Coding Policy) for additional details. This information is to be used as a reference and is not an all-inclusive list of possible coding edits applied by Company.

CONTENTS

04.0.01 Removal of IUD billed with E/M Services
04.0.05 E/M Services billed with Diagnostic Indirect Laryngoscopy
04.0.06 Interpretation and Report of EKG Rhythm Strip, 1-3 Leads billed with E/M Services
04.0.07 Interpretation and Report of 12-Lead Routine EKG billed with E/M Services
04.0.09 E/M Services billed with Anoscopy
04.0.10 Demonstration/Evaluation of Patient Utilization of Nebulizer, Inhaler, or IPPB Device billed with E/M Services
04.0.11 Urinalysis, Dip Stick billed with E/M Services
04.0.12 Binocular Microscopy billed with E/M Services
04.0.14 Lumbar Laminectomy billed with Interbody Arthrodesis
04.0.15 Operating Microscopy billed with Procedures Not Listed
04.0.16 Laminotomy billed with Laminectomy for Contiguous Levels of Spine
04.0.17 Hearing and Vision Screening
04.0.18 Problem-Related E/M Services billed with Preventive E/M Services
04.0.19 Multiple Units of Dosimetry Calculations, Treatment Devices, and Multi-Leaf Collimator (MLC) Devices for IMRT for Radiation Oncology
04.0.20 Exploration of Spinal Fusion billed with Related Spine Surgeries
04.0.21 Open Treatment of Femoral Fracture, Medial or Lateral Condyle billed with Open Treatment of Supracondylar or Transcondylar Femoral Fracture
04.0.22 Arthroscopic Removal of Loose Body or Foreign Body from Hip billed with Arthroscopic Chondroplasty of Hip or Arthroscopic Synovectomy of Hip
04.0.23 Laryngoscopy with Injection to Vocal Cords billed with Laryngoscopy with Dilation
04.0.24 Endocervical Curettage billed with Colposcopy of the Cervix
04.0.26 Chromotubation of Oviduct billed with Surgical Hysteroscopy
04.0.27 Parathyroid Autotransplantation billed with Parathyroidectomy
04.0.28 Esophagoscopy with Biopsy and EGD with Biopsy billed with ERCP

04.0.29 EHR Assessment and Management Consultation billed within 30 Days of E/M or Procedure
04.0.30 E/M Services billed with Simple Control of Nasal Hemorrhage
04.0.31 Cerumen Removal
04.0.32 Nasal Endoscopy with Debridement billed with E/M Services
04.0.33 Ovarian cystectomy billed with Oophorectomy
04.0.34 Elective Cardioversion billed with Critical Care
04.0.35 Health and Wellness Coaching
04.0.36 HCPCS Code G2211
04.0.37 Intraoperative Angiography

POLICIES

Table 1: 04.0.01

Removal of Intrauterine Device billed with Evaluation and Management Services		
Codes	99202-99499	E/M Services
	58301	Removal of intrauterine device (IUD)
Effective Date	8/2001	
Policy	Evaluation and Management (E/M) services billed with an IUD-related primary diagnosis on the same date of service as IUD removal (CPT code 58301) will be denied, regardless of CCI edits or modifier use. CPT code 58301 has a global period of 000 days, meaning E/M services provided on the same day of the procedure are generally not separately payable. The evaluation required to remove an IUD is included in payment for the procedure itself. A separate E/M service should only be billed if the provider addressed a different, unrelated issue during the same visit. Company may pay for an E/M visit with removal of an IUD 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 for IUD removal, and no significant, separately identifiable E/M visit is documented, CPT code 58301 should be billed without an E/M code.	

Table 2: 04.0.05

Evaluation and Management Services billed with Diagnostic Indirect Laryngoscopy		
Codes	99202-99499	E/M Services
	31505	Laryngoscopy, indirect; diagnostic (separate procedure)
Effective Date	9/2003	
Policy	When Evaluation and Management (E/M) services are billed with diagnostic indirect laryngoscopy (CPT code 31505), standard Correct Coding Initiative (CCI) edits apply. However, Company does not allow the use of modifier -25 to override the CCI edit in this scenario. Reimbursement for the E/M service appended with modifier 25 may be considered on appeal only if documentation clearly supports that the E/M service was significant and separately identifiable, in accordance with Coding Policy	

	31.0 (Modifier -25: Evaluation and Management Same Day as Procedure or Other Service).

Table 3: 04.0.06

Interpretation and Report of ECG Rhythm Strip, 1-3 Leads billed with Evaluation and Management Services		
Codes	93042	Rhythm ECG, one to three leads; interpretation and report only
	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 4: 04.0.07

Interpretation and Report of 12-Lead Routine Electrocardiogram billed with Evaluation and Management Services		
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 5: 04.0.09

Evaluation and Management Services billed with Anoscopy		
Codes	99202-99499	E/M Services

	46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Effective Date	3/2010	
Policy	When Evaluation and Management (E/M) services are billed with diagnostic anoscopy (CPT code 46600), standard Correct Coding Initiative (CCI) edits apply. However, Company does not allow the use of modifier -25 to override the CCI edit in this scenario. Reimbursement for the E/M service appended with modifier 25 may be considered on appeal only if documentation clearly supports that the E/M service was significant and separately identifiable, in accordance with Coding Policy 31.0 (Modifier -25: Evaluation and Management Same Day as Procedure or Other Service)..	

Table 6: 04.0.10

Demonstration/Evaluation of Patient Utilization of Nebulizer, Inhaler, or IPPB Device billed with Evaluation and Management Services		
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. Instructing a patient on the proper use of a medication is considered part of the overall management of the patient. 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. Reporting both procedure codes on the same day represents an overlap of services and separate reimbursement is not warranted.	

Table 7: 04.0.11

Urinalysis, Dip Stick billed with Evaluation and Management Services		
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 8: 04.0.12

Binocular Microscopy billed with Evaluation and Management Services		
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 9: 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. When supported by the documentation, Company pays add-on codes 63052 and 63053 (Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar) when billed in conjunction with CPT codes 22630, 22632, 22633, or 22634.	

Table 10: 04.0.15

Operating Microscopy 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 11: 04.0.16

CPT Codes 63020-63030 or 63040-63042 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 12: 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 13: 04.0.18

Problem-Related Evaluation and Management Services 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 14: 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)

Company follows CMS guidance for multiple units of CPT code 77338. The National Correct Coding Initiative (NCCI) Policy Manual states: “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.”

CPT code 77338 may be reported once per IMRT plan (CPT code 77301). In rare cases, billing a second IMRT plan during the same course of therapy may be warranted. If performed, an additional statement from the physician supporting medical necessity is required and must be present within the patient’s medical

	record. In the event additional IMRT planning is performed without a new CT data set, the IMRT plan (CPT code 77301) is not billable. Company will allow a maximum of one unit of CPT code 77338 within a 90-day period. One additional unit may be paid on appeal if the patient's medical record shows IMRT planning performed with a new CT data set to support a second unit of CPT code 77301. Additional units of CPT code 77338 within the same 90-day treatment period will be allowed only if documentation is submitted showing a new IMRT plan for a different treatment area.

Table 15: 04.0.20

Exploration of Spinal Fusion 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 16: 04.0.21

Open Treatment of Femoral Fracture, Medial or Lateral Condyle (27514) 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 17: 04.0.22

Arthroscopic Removal of Loose Body or Foreign Body From Hip (29861) 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 18: 04.0.23

Laryngoscopy with Injection to Vocal Cords billed with Laryngoscopy with Dilation		
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 19: 04.0.24

Endocervical Curettage billed with Colposcopy of the Cervix		
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 20: 04.0.26

Chromotubation of Oviduct billed with Surgical Hysteroscopy

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 21: 04.0.27

Parathyroid Autotransplantation billed with Parathyroidectomy		
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 22: 04.0.28

Esophagoscopy With Biopsy (43202) and EGD With Biopsy (43239) billed with ERCP (43260-43265 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	When an Endoscopic Retrograde Cholangiopancreatography (ERCP) is billed, CPT codes 43202 (Esophagoscopy with biopsy) and 43239 (EGD with biopsy) will be denied if submitted for the same session. This policy is based on the National Correct Coding Initiative (NCCI) Policy Manual and CPT coding Guidelines. Chapter 6 of the NCCI Policy Manual, Section C, states the following: 2. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered shall be reported. If multiple services are performed and not adequately described by a single HCPCS/CPT code, more than one code may be reported… Only medically necessary services may be reported. Incidental examination of other areas shall not be reported separately.	

	3. If the same endoscopic procedure (e.g., polypectomy) is performed multiple times at a single patient encounter in the same region as defined by the CPT Professional codebook narrative, only one CPT code may be reported with one unit of service. 12. **Only the more extensive endoscopic procedure may be reported for a patient encounter.** For example if a sigmoidoscopy is completed and the physician also performs a colonoscopy during the same patient encounter, only the colonoscopy, may be reported. An ERCP is a comprehensive procedure that inherently includes passage through the upper gastrointestinal tract (i.e. esophagus, stomach, and duodenum) to access the biliary tract. **When medically necessary biopsies are performed during an ERCP, they should be reported using CPT code 43261.** It is not appropriate to report CPT codes 43202 or 43239 for biopsies obtained during an ERCP because endoscopic evaluation of the upper GI tract is included in the more extensive ERCP service.

Table 23: 04.0.29

Electronic Health Record Assessment and Management Consultation (99451) 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 24: 04.0.30

Evaluation and Management Services billed with Simple Anterior Control of Nasal Hemorrhage		
Codes	99202-99499	E/M Services
	30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
Effective Date	9/2017	
Policy	Evaluation and Management (E/M) services billed with a primary diagnosis of epistaxis (R04.0) on the same date of service as simple anterior control of nasal hemorrhage (CPT code 30901) will be denied, regardless of CCI edits or modifier use. CPT code 30901 has a global period of 000 days, meaning E/M services provided on the same day of the procedure are generally not separately payable. The evaluation required to treat a simple nosebleed is included in payment for the procedure itself. A separate E/M service should only be billed if the provider addressed a different, unrelated issue during the same visit. Reimbursement for the E/M service may be considered on appeal only if documentation clearly shows that the E/M meets the criteria for a significant and separately identifiable service per Coding Policy 31.0 (Modifier -25: Evaluation and Management Same Day as Procedure or Other Service).	

Table 25: 04.0.31

Cerumen Removal		
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	**A. Cerumen Removal** Company will only cover cerumen removal (CPT codes 69209 and 69210) when reported with a diagnosis of impacted cerumen (diagnosis codes H61.21-H61.23). Removing wax that is not impacted does not warrant reporting a separate procedure code; that work would appropriately be reported using an evaluation and management (E/M) code regardless of how it is removed (e.g. lavage, curette, suction, etc.). Cerumen removal is not reportable in situations where the removal was required for visualization of the ear to address the chief complaint. CPT code 69210 may only be reported when a physician or other qualified health care professional utilizes instruments to remove impacted cerumen. 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); use of suction alone does not support reporting code 69210. The documentation must identify the specific instrument(s) used during the encounter. CPT code 69210 may not be reported when a nurse or other clinical staff performs the cerumen removal. Company does not accept CPT code 69210 appended with modifier 50. See Coding Policy 14.0 (Bilateral Procedures). **B. E/M Services with Cerumen Removal** When the sole reason for the visit is removal of symptomatic impacted cerumen, an E/M service may not be billed in addition to the cerumen removal. E/M services billed with a primary diagnosis of impacted cerumen (codes H61.20-H61.23) or otalgia (codes H92.01-H92.09) on the same date of service as cerumen removal (codes 69209 or 69210) will be denied, regardless of CCI edits or modifier use. Cerumen removal codes 69209 and 69210 have a global period of 000 days, meaning E/M services provided on the same day of the procedure are generally not separately payable. The evaluation required to treat impacted cerumen is included in payment for the procedure itself. An E/M service on the same day as removal of impacted cerumen may not be billed unless it is a significant, separately identifiable service. For example: • If pain in the external ear is the only complaint and the removal of impacted cerumen addresses that complaint, only the wax removal is reportable. • If the patient also has symptoms of otitis media requiring further evaluation, then it may be justified to also bill for an E/M service with modifier –25. Reimbursement for the E/M service may be considered on appeal only if documentation clearly shows that the E/M meets the criteria for a significant and separately identifiable service per Coding Policy 31.0 (Modifier -25: Evaluation and Management Same Day as Procedure or Other Service).

Table 26: 04.0.32

Nasal Endoscopy with Debridement billed with E/M Services		
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 27: 04.0.33

Ovarian cystectomy billed with Oophorectomy		
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 28: 04.0.34

Elective Cardioversion billed with Critical Care		
Codes	92960	Cardioversion, elective, electrical conversion of arrhythmia; external
	99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
	99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
Effective Date	11/2025	
Policy	Company follows National Correct Coding Initiative (NCCI) Policy Manual guidelines for CPT code 92960. Do not use CPT code 92960 to report defibrillation. There is no CPT code for emergency cardiac defibrillation; it is included in cardiopulmonary resuscitation (CPT code 92950). If defibrillation occurs without CPR, it is not separately reportable. The place of service does not determine whether a cardioversion is considered emergent or elective (planned); with respect to cardioversion, the intent is that it was not part of emergency resuscitation. If the patient can be given an explanation of the procedure and/or consent, the cardioversion is considered elective. Time spent performing an elective cardioversion should not be counted towards any critical care time reported with CPT codes 99291 and 99292.	

Table 29: 04.0.35

Health and Wellness Coaching		
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 30: 04.0.36

HCPCS Code G2211		
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 home or residence or office/outpatient evaluation and managementservice, 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
	99341-99345	Home or residence visit for the evaluation and management of a new patient
	99347-99350	Home or residence visit for the evaluation and management of an established patient
Effective Date	1/2024	
Policy	Effective for dates of service on or after November 1, 2024, HCPCS code G2211 (E/M complexity add-on code) is allowed **only** for Medicare Advantage lines of business. Company follows CMS guidance regarding HCPCS code G2211 for Medicare Advantage lines of business. Effective 01/01/26 HCPCS code G2211 may be reported with home or residence evaluation and management codes. Note: G2211 is not allowed when the associated E/M visit is billed with modifier 25 for the same patient by the same practitioner, unless the additional service requiring the reporting of modifier 25 is an allowed preventive service. *Please refer to CMS billing instructions in effect at the time services were rendered.*	

Table 31: 04.0.37

Intraoperative Angiography

Codes	15860	Intravenous Injection of agent (eg, fluorescein) to test vascular flow in flap or graft
Effective Date	11/2025	
Policy	During surgery, any assessment of vascular patency, tissue viability, perfusion, or organ identification is considered integral to the primary procedure and is not eligible for separate reimbursement. Intraoperative angiography (e.g. SPY, firefly, pinpoint endoscopic fluorescence imaging, etc.) used for these assessments should not be billed separately. These techniques are considered incidental to the associated surgical procedure. Company will deny reimbursement for CPT code 15860 when it is billed with other surgical codes on the same date of service. This code may only be eligible for reimbursement if it is the sole service performed on a particular date of service, or upon appeal if documentation shows it is clinically unrelated to the other surgical services reported on the same date.	

CROSS REFERENCES

- Coding Policy 14.0 (Bilateral Procedures)
- Coding Policy 31.0 (Modifier -25: Evaluation and Management Same Day as Procedure or Other Service)

REFERENCES

1. Centers for Medicare and Medicaid Services (cms.gov)
2. MLN Matters Number MM13473 – How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

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.
4/2024	Updated Table 19 (04.0.19) to show course of therapy for maximum frequency edits for CPT codes 77332-77334 and 77338 is 90 days. Updated information about maximum units of CPT code 77338 to show additional units of code 77338 may be paid only if billed in conjunction with CPT code 77301.

9/2024	Added information showing HCPCS code G2211 is allowed only for Medicare Advantage for dates of service on or after 11/1/2024.
1/2025	Added information to Table 04.0.14 to show that CPT codes 63052 and 63053 are allowed with CPT codes 22630, 22632, 22633, 22634 when supported by documentation. Updated Table 04.0.36 to show HCPCS G2211 is allowed when billed with E/M visit with modifier 25 if codes identified in the policy are also on the claim (based on CMS Transmittal 13015 dated 12/23/2024).
11/2025	Interim update. Policy 04.0.28 rationale updated. Policy 04.0.34 removed denial of 92960 in the ED and addressed time overlap with critical care. Added Policy 04.0.37.
1/2026	Interim update. Updated policy 04.0.36 to show G2211 may be reported with code 99341-99350 for Medicare lines of business. Revised policies 04.0.01, 04.0.05, 04.0.09, 04.0.30, and 04.0.31 - E/M services are allowed with codes 30901, 31505, 46600, 58301, 69209, or 69210 if the documentation supports the service as significant and separately identifiable on appeal. Retired policies 04.0.02, 04.0.03, 04.0.08, 04.0.13, and 04.0.25. Revised policy 04.0.31 – Cerumen removal is only covered for diagnosis of impacted cerumen. Updated policy 04.0.36 to reference CMS guidelines in lieu of listing all exceptions.
3/2026	Interim update. Revised code description for HCPCS code G2211.