Chapter V
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems
CPT Codes 30000 – 39999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the Current Procedural Terminology (CPT) codes in the range 30000-39999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Providers/suppliers shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A provider/supplier shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A provider/supplier shall not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation & Management (E&M) Services

This section summarizes some of the Medicare Global Surgery Rules for reporting Evaluation & Management (E&M) services in the global period.

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

Since National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to the NCCI program. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 days under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a

major surgical procedure are included in the global payment for the procedure and are not separately reportable. The NCCI program does not contain edits based on this rule because MACs have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period"), unless related to a complication of surgery.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall **not** be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A provider/supplier shall **not** report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure, but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Respiratory System

1. The nose and mouth have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999), a nasal procedure (CPT codes 30000-30999), or an oral procedure (CPT codes 40000-40899). If a procedure is performed on a lesion at or

near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the respiratory system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) shall not be reported separately.

2. A biopsy performed in conjunction with a more extensive nasal/sinus procedure is not separately reportable unless the biopsy is examined pathologically before the more extensive procedure and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination.

   Example

   If a patient presents with nasal obstruction, sinus obstruction, and multiple nasal polyps, it may be reasonable to perform a biopsy before, or in conjunction with, polypectomy and ethmoidectomy. A separate biopsy code (e.g., CPT code 31237 for nasal/sinus endoscopy) shall not be reported with the removal nasal/sinus endoscopy code (e.g., CPT code 31255) because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic or surgical endoscopy of the respiratory system is performed, it is a standard of practice to evaluate the access regions. A separate HCPCS/CPT code shall not be reported for this evaluation of the access regions. For example, if an endoscopic anterior ethmoidectomy is performed, a diagnostic nasal endoscopy shall not be reported separately simply because the approach to the ethmoid sinus is transnasal. Similarly, fiberoptic bronchoscopy routinely includes an examination of the nasal cavity, pharynx, and larynx. A separate HCPCS/CPT code shall not be reported with the bronchoscopy HCPCS/CPT code for this latter examination whether it is limited (“cursory”) or complete.

   If medically reasonable and necessary endoscopic procedures are performed on 2 regions of the respiratory system with different types of endoscopes, both procedures may be separately reportable. For example, if a patient requires diagnostic bronchoscopy for a lung mass with a fiberoptic bronchoscope and a separate laryngoscopy for a laryngeal mass with a fiberoptic laryngoscope at the same patient encounter, HCPCS/CPT codes for both procedures may be reported separately. It must be medically reasonable and necessary to use 2 separate endoscopes to report both codes.

   If the findings of a diagnostic endoscopy lead to the decision to perform a non-endoscopic surgical procedure at the same patient encounter, the diagnostic endoscopy may be reported separately. However, if an endoscopic procedure to evaluate the surgical field (e.g., confirmation of anatomic structures, assess extent of disease, confirmation of adequacy of surgical procedure such as tracheostomy) is performed at the same patient encounter as an open surgical procedure, the endoscopic procedure is not separately reportable.

If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure that no intraoperative injury occurred or to verify that the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

A diagnostic endoscopy is not separately reportable with a surgical endoscopy, per *CPT Professional* instructions. If an endoscopic procedure fails and is converted into an open procedure, the endoscopic procedure is not separately reportable with the open procedure. Neither the surgical endoscopy nor diagnostic endoscopy code shall be reported with the open procedure code when a surgical endoscopy is converted to an open procedure.

Example

A patient presents with aspiration of a foreign body. A bronchoscopy is performed identifying lobar foreign body obstruction, and an attempt is made to remove this obstruction during the bronchoscopy. It would be inappropriate to report CPT codes 31622 (Diagnostic bronchoscopy) and 31635 (Surgical bronchoscopy with removal of foreign body). Only the "surgical" endoscopy, CPT code 31635, may be reported. In this example, if the endoscopic effort fails and a thoracotomy is performed, the diagnostic bronchoscopy may be reported separately in addition to the thoracotomy. Modifier 58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. However, the CPT code for the surgical bronchoscopy to remove the foreign body is not separately reportable because the procedure was converted to an open procedure. If the surgeon decides to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, this confirmatory bronchoscopy is not separately reportable although the initial diagnostic bronchoscopy may still be reportable.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service may be reported. *CPT Professional* instructions indicate that surgical sinus endoscopy includes a sinusotomy (if appropriate) and a diagnostic sinus endoscopy. However, if the medically necessary procedure is a sinusotomy and a sinus endoscopy is performed to evaluate adequacy of the sinusotomy and visualize the sinus cavity for disease, it may be appropriate to report the sinusotomy HCPCS/CPT code rather than the sinus endoscopy HCPCS/CPT code.

5. Control of bleeding is an integral component of endoscopic procedures, and is not separately reportable. For example, control of nasal hemorrhage (CPT code 30901) is not separately reportable for control of bleeding due to a nasal/sinus endoscopic procedure. If bleeding occurs in the postoperative period and requires return to the operating room for treatment, a HCPCS/CPT code for control of the bleeding may be reported with modifier 78 indicating that the procedure was a complication of a prior procedure requiring treatment in the operating room. However, control of postoperative bleeding not requiring return to the operating room is not separately reportable.

Like CPT code 30901, CPT codes 30801 (Ablation, soft tissue of inferior turbinates...; superficial), 30903 (Control of hemorrhage, anterior...), 30905 (Control of hemorrhage, posterior...), and 31238 (Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage) shall not be reported separately for control of bleeding due to a nasal/sinus endoscopic procedure or other nasal procedure.

6. When endoscopic service(s) are performed, the most comprehensive code describing the service(s) rendered shall be reported. If multiple services are performed and are not adequately described by a single CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended to the secondary service CPT code(s). Additionally, only medically necessary services may be reported. Incidental examination of other areas shall not be reported separately.

7. CPT codes 31292 (Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall), 31293 (Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall), and 31294 (Nasal/sinus endoscopy, surgical; with optic nerve decompression) describe nasal/sinus endoscopy, surgical with orbital decompression; medial or inferior wall. These procedures include the following procedures, which shall not be reported separately when performed on the ipsilateral side: CPT codes 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy;), 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus), 31276 (Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed), 31287 (Nasal/sinus endoscopy, surgical, with sphenoidotomy;), and 31288 (Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus). CPT code 30130 (Excision inferior turbinate, partial or complete, any method) is also included and not separately reportable if performed on the ipsilateral side to allow access to the ethmoid or other sinuses to perform the procedures described by CPT codes 31292-31294. However, CPT code 30130 may be reported separately, if performed on the ipsilateral side, for a purpose unrelated to allowing access to the sinuses to perform the procedures described by CPT codes 31292-31294. If any of the included procedures are performed on the contralateral side from the procedures described by CPT codes 31292-31294, they may be reported separately.

8. Flexible laryngoscopy and direct laryngoscopy shall not be reported for the same patient encounter.

9. Lavage by cannulation of a respiratory accessory sinus (e.g., CPT codes 31000 (Maxillary sinus), 31002 (Sphenoid sinus)) is an integral component when performed with a more definitive procedure on that sinus. Lavage by cannulation shall not be reported separately with another code describing a more definitive sinus procedure (e.g., CPT codes 31256, 31267, 31295) when performed on the ipsilateral sinus at the same patient encounter.

10. If laryngoscopy is required for elective or emergency placement of an endotracheal tube, the laryngoscopy is not separately reportable. CPT code 31500 describes an emergency endotracheal intubation procedure and shall not be reported when an elective intubation is

performed. For example, if intubation is performed in a rapidly deteriorating patient who requires mechanical ventilation, a separate HCPCS/CPT code may be reported for the emergent intubation. The medical record must document the necessity for emergent intubation.

11. An emergency endotracheal intubation procedure (CPT code 31500) is normally followed by a chest radiologic examination to confirm proper positioning of the endotracheal tube. A chest radiologic examination CPT code (e.g., 71045, 71046) shall not be reported separately for this radiologic examination.

12. The descriptor for CPT code 31600 (Tracheostomy, planned (separate procedure)) includes the "separate procedure" designation. Therefore, pursuant to the Centers for Medicare & Medicaid Services (CMS) "separate procedure" policy, a tracheostomy is not separately reportable with laryngeal surgical procedures that frequently require tracheostomy (e.g., laryngotomy, laryngectomy, laryngoplasty).

13. If laryngoscopy is required for placement of a tracheostomy, the tracheostomy (CPT codes 31600-31610) may be reported. The laryngoscopy is not separately reportable.

14. CPT code 92511 (Nasopharyngoscopy with endoscope (separate procedure)) shall not be reported separately when performed as a cursory examination with other respiratory endoscopic procedures.

15. A diagnostic thoracoscopy (CPT codes 32601, 32604, 32606) is not separately reportable with a surgical thoracoscopy on the ipsilateral side of the thorax.

    A diagnostic thoracoscopy to assess the surgical field or extent of disease before an open thoracotomy, thoracostomy, or mediastinal procedure is not separately reportable. However, a diagnostic thoracoscopy is separately reportable with an open thoracotomy, thoracostomy, or mediastinal procedure if the findings of the diagnostic thoracoscopy lead to the decision to perform an open thoracotomy, thoracostomy, or mediastinal procedure. Modifier 58 may be reported to indicate that the diagnostic thoracoscopy and open procedure were staged or planned.

    If a surgical thoracoscopy is converted to an open thoracotomy, thoracostomy, or mediastinal procedure, the surgical thoracoscopy is not separately reportable. Additionally, a diagnostic thoracoscopy shall not be reported in lieu of the surgical thoracoscopy with the open thoracotomy, thoracostomy, or mediastinal procedure. Neither a surgical thoracoscopy nor diagnostic thoracoscopy code shall be reported with the open thoracotomy, thoracostomy, or mediastinal procedure code when a surgical thoracoscopy is converted to an open procedure.

16. Open procedures of the thorax include the approach and exploration. CPT code 32100 (thoracotomy; with exploration) shall not be reported separately with open thoracic procedures to describe the approach and exploration. CPT code 32100 may be separately reportable with an open thoracic procedure if: (1) it is performed on the contralateral side;

(2) it is performed on the ipsilateral side through a separate skin incision; or (3) it is performed to obtain a biopsy at a different site than the other open thoracic procedure.

17. A tube thoracostomy (CPT code 32551) may be performed for drainage of an abscess, empyema, or hemothorax. The code descriptor for CPT code 32551 defines it as a "separate procedure." It is not separately reportable when performed at the same patient encounter as another open procedure of the thorax unless it is performed in the thoracic cavity contralateral to the one entered to perform the open thoracic procedure.

18. A pleural drainage procedure (e.g., CPT codes 32556, 32557), thoracentesis procedure (e.g., CPT codes 32554, 32555), or chest tube insertion procedure (e.g., CPT codes 32550, 32551) is often followed by a chest radiologic examination to confirm adequacy of the procedure, lack of complications, or the proper location and positioning of the chest tube. A chest radiologic examination CPT code (e.g., 71045, 71046) shall not be reported separately for this radiologic examination.

19. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

20. The procedures described by CPT codes 30801 and 30802 (Cautery and/or ablation of mucosa of inferior turbinates) are performed to reduce the size of the inferior turbinates of the nose. These 2 codes shall not be reported for access to the nose or sinuses or for control of intraoperative bleeding with other codes describing nasal or sinus endoscopy or other nasal procedures. Since the procedure described by CPT code 30802 (Intramural, unilateral or bilateral) is more extensive than the procedure described by CPT code 30801 (Superficial, unilateral, or bilateral), both codes shall not be reported for the same patient encounter.

21. A diagnostic biopsy(s) of the lung from an anatomic location removed during a more extensive procedure (e.g., segmentectomy, lobectomy, thoracoscopic (VATS) lobectomy) at the same patient encounter is not separately reportable with the more extensive procedure. This principle is applicable whether the lung biopsy(s) is examined pathologically during the intraoperative procedure or postoperatively. This principle is applicable whether the biopsy(s) is for purposes of diagnosis, determining whether the more extensive procedure should be performed, or determining the extent of the more extensive procedure. This principle is also applicable regardless of the surgical approach (i.e., open or thoracoscopic (VATS)) or technique (e.g., incisional, excisional, resection, stapled wedge) to perform the biopsy(s).

    A diagnostic biopsy(s) of the lung is separately reportable with a more extensive lung procedure performed at the same patient encounter if the anatomic location of the biopsy is not included in the more extensive procedure.

22. CPT codes that describe excision of all lung tissue from a thoracic cavity (e.g., 32440, 32442, 32445, 32488) include thoracotomy with exploration (CPT code 32100), open intrapleural pneumonolysis (CPT code 32124), control of traumatic hemorrhage and/or