CORRECT CODING INITIATIVE
OB/GYN CPT CODES

INTRODUCTION

2017

NOTE: CMS UPDATES THE CCI QUARTERLY.
FOR THE MOST RECENT VERSION,
SEE DEPT. OF HEALTH ECONOMICS AND CODING
WWW.ACOG.ORG
INTRODUCTION

On January 1, 1995, the Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services or CMS) implemented a comprehensive national policy regarding bundling of services billed to Medicare. This policy, called the Correct Coding Initiative (CCI), is intended to promote consistency in bundling and unbundling of services throughout the United States.

- **Bundling** is the inclusion of lesser procedures in the payment for a more comprehensive procedure performed during the same session. Only the comprehensive procedure is reported on the claim form.

- **Unbundling** is the separate reporting of two or more services that should have been bundled. Only one of the services should have been reported on the claim form.

The CCI policies developed by CMS are based on:

- Coding conventions in the American Medical Association’s CPT® manual
- Medicare national and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice
- Review of current coding practices using claims submitted to Medicare

The CCI is updated quarterly. New versions become effective January 1, April 1, July 1, and October 1 of each year. Changes in CCI come from these sources:

- Changes in CPT or HCPCS codes or in CPT instructions
- CMS policy initiatives
- Comments from AMA, national or local specialty societies, Medicare contractor medical directors, providers, billing consultants or other interested individuals.

Physicians should check the ACOG website (www.acog.org, Department of Health Economics and Coding) each quarter to obtain the most recent version of the CCI.

All policies and edits in the Correct Coding Initiative assume the following:

- The same physician is billing all of the CPT codes involved.
- The services are provided for the same beneficiary and on the same day.

Physicians who believe that certain procedure codes are inappropriately bundled are encouraged to contact ACOG so that formal arguments can be submitted to CMS. ACOG has had some success in the past in persuading CMS to modify its published bundles. Please direct your request to the Department of Health Economics and Coding by registering here at: https://acogcoding.freshdesk.com.
CCI DEFINITIONS
The CCI presents “code pairs,” procedure codes that may not be reported if performed at the same operative session by the same surgeon. That is, the codes are considered bundled. There are two kinds of code pairs: mutually exclusive and column 1/column 2 pairs.

Mutually exclusive code pairs cannot reasonably be done in the same session. Some examples are:
- A code that is performed only on females and a code that is performed only on males
- Multiple approaches to the same procedure
- An initial service and a subsequent service

Column 1/Column 2 code pairs include a comprehensive code (column 1) and a code that is considered a component of that code (column 2). In most cases, the column 2 code will not be reimbursed when reported with the column 1 code. Examples are described below.

GENERAL GUIDELINES – EXAMPLES OF INAPPROPRIATE UNBUNDLING
The introduction to the CCI provides examples of inappropriate unbundling:

Fragmenting one service into its component parts and coding each component as if it were a separate service.
For example, a cervical colposcopy with biopsy and endocervical curettage is reported using code 57454. It is inappropriate to report this service using codes 57455 (colposcopy with biopsy) and 57456 (colposcopy with endocervical curettage).

Reporting separate codes for related services when one comprehensive code includes all related services.
For example, a total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries is reported using code 58150. It is inappropriate to report this service using code 58150 (hysterectomy), 58940 (oophorectomy) and 58700 (salpingectomy).

Breaking out bilateral procedures when one code is appropriate.
For example, a bilateral mammography is reported using code 77056. It is inappropriate to report this service using codes 77056-RT (mammography, unilateral) for the right breast and 77056-LT (mammography, unilateral) for the left breast.

Reporting separate codes for a surgical approach and the surgical service.
For example, a total abdominal hysterectomy is reported using code 58150. It is inappropriate to report this service using codes 58150 and 49000 (exploratory laparotomy) to indicate the approach used. The exploration of the surgical field is included in the surgical code.
GENERAL GUIDELINES—EXAMPLES OF BUNDLING RULES
The CCI also describes some general rules used by CMS to decide which services should be bundled.

Bundles Based on Standards of Medical/Surgical Practice
The lesser (column 2) service is considered “generic,” meaning the service is commonly part of all similar procedures. The services are bundled because the lesser service:

- Represents the standard of care in accomplishing the comprehensive procedure,
- Is necessary to successfully accomplish the procedure (failure to perform the service may compromise the success of the procedure), and
- Is not a separately identifiable procedure unrelated to the column 1 procedure.

These generic services include procedures to gain access to the organ system (e.g., lysis of adhesions or exploratory procedure performed with abdominal surgery) and surgical closure.

Bundles Based on Medical/Surgical Package Definitions
A CPT code includes all the work typically associated with the surgical or medical service described by the code. Both Medicare and CPT have specific definitions of the global package of services included or not included in a code. See ACOG’s booklet, Procedural Coding in Obstetrics & Gynecology for a discussion of the global package.

Bundles Based on CPT Descriptions Indicating a Comprehensive/Lesser Service
The descriptions of procedures often indicate a comprehensive/lesser service relationship. For example, code 56620 (partial vulvectomy) is a component of code 56625 (complete vulvectomy); and code 57100 (simple biopsy of the vaginal mucosa) is a component of code 57105 (extensive biopsy of vaginal mucosa, requiring suture).

Bundles Based on Sequential Procedures
An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. The second procedure is usually performed because the initial approach was unsuccessful. Only the CPT code for one of the services, generally the more invasive one, is reported.

Bundles Based on Separate Procedures
The CCI uses CPT’s term “separate procedure” to define bundled services, but defines the term more narrowly than CPT does.

CPT defines a separate procedure as one that is “commonly carried out as an integral component of a total service or procedure.” A separate procedure can be reported with other procedures if it “is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time.”

The CCI defines a separate procedure as one that “should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice.” A separate procedure can be reported with other procedures if it “is performed on the same day but at a different session, or at an anatomically unrelated site.”

If appropriate, report the separate procedure code using a modifier 59 (distinct procedural service).
Bundles Based on Families of Codes
A code family is a comprehensive code that includes two or more component codes. If all the services of the component codes are performed, then the comprehensive code is reported. If, on the other hand, some but not all of the component codes are performed, then the comprehensive code is not reported. Each component code is reported separately.

For example, code 59400 (routine obstetric care including antepartum care, vaginal delivery and postpartum care) is the comprehensive code which includes these component codes in its family: antepartum only codes 59425 and 59426, postpartum care only code 59430, vaginal delivery only code 59409 and vaginal delivery including postpartum care code 59410. If any of these component services are not performed, code 59400 cannot be reported. Report only those component codes that describe the services that were actually provided.

Modifiers and Exceptions to the Bundling Rules
There are exceptions to the bundles listed in the CCI. Medicare may reimburse for some code pairs if the physician documents that the procedures were distinct. In most cases, the distinct services were provided during separate patient encounters or involved separate anatomic sites or separate specimens.

A modifier must be used to indicate that the procedures in this specific instance were distinct and reportable; that is, not bundled. Medicare accepts only these modifiers: HCPCS anatomic modifiers (e.g., LT and RT); CPT modifier 58 (staged or related procedure); and CPT modifier 59 (distinct procedural service).

There are some codes that Medicare will never reimburse when reported with their comprehensive codes, even if a modifier is used and documentation submitted with the claim.

The use of modifier 59 was discussed in the section above on bundles based on separate procedures. Following are some other examples of when adding a modifier to a bundled code may or may not be appropriate.

Different Sides of the Body
For example, code 58805 (drainage of ovarian cyst, abdominal approach) is bundled into 58940 (oophorectomy). These are sequential procedures, and therefore bundled. It is assumed that the procedures were performed on the same organ, same side of the body.

If the drainage of the cyst was performed on the right ovary and the oophorectomy was performed on the left ovary, both codes are reported. Use modifiers LT and RT on the codes.

Biopsy of Lesions
If a single lesion is biopsied multiple times, one biopsy code is reported.

If a non-diagnostic biopsy is performed and then the lesion is removed or destroyed, report only the code for the removal or destruction of the lesion.

If multiple biopsies of one or more lesions are performed using an endoscope, report only one biopsy code. Use modifier 59. This indicates that a different service was performed or that a different site was biopsied.
Endoscopy Performed at the Same Time as an Open Procedure

If an endoscopy is performed to establish the location of a lesion, confirm the presence of a lesion, establish anatomic landmarks or define the extent of a lesion, the endoscopic service is not reported separately. It is considered a medically necessary part of the overall service.

If an endoscopy procedure is attempted and fails and another surgical service is necessary, only the successful service is reported.

If an endoscopy procedure is a distinct diagnostic service and is the basis for the decision to perform an open procedure, report both the endoscopy and the open procedure. Use modifier 58 on the endoscopy code.

CCI FORMAT

The first two unshaded rows list the bundles for comprehensive code 57550. The two shaded rows list the codes bundled into comprehensive code 57555. An example follows:

| 57550-May Be Paid                                                                 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12001 | 12002 | 12004 | 12005 | 12006 | 12007 | 12011 | 12013 | 12014 | 12015 | 12016 | 12017 | 12018 | 12020 | 12021 |
| 12031 | 12032 | 12034 | 12035 | 12036 | 12037 | 12041 | 12042 | 12044 | 12045 | 12046 | 12047 | 12051 | 12052 | 12053 |
| 12054 | 12055 | 12056 | 12057 | 13100 | 13101 | 13102 | 13120 | 13121 | 13122 | 13131 | 13132 | 13133 | 13151 | 13152 |
| 13153 | 36000 | 36400 | 36405 | 36406 | 36410 | 36420 | 36425 | 36430 | 36440 | 36600 | 36640 | 37202 | 43752 | 50715 |
| 52000 | 57105 | 57200 | 57210 | 57421 | 57522 | 57545 | 92012 | 92014 | 93000 | 93005 | 93010 | 93040 | 93041 | 93042 |
| 93318 | 93355 | 94002 | 94200 | 94250 | 94680 | 94681 | 94690 | 94770 | 95812 | 95813 | 95816 | 95819 | 95822 | 95829 |
| 95955 | 96360 | 96365 | 96372 | 96374 | 96375 | 96376 | 99211 | 99212 | 99213 | 99214 | 99215 | 99217 | 99218 | 99219 |
| 99220 | 99221 | 99222 | 99223 | 99231 | 99232 | 99233 | 99234 | 99235 | 99236 | 99238 | 99239 | 99241 | 99242 | 99243 |
| 99244 | 99245 | 99251 | 99252 | 99253 | 99254 | 99255 | 99256 | 99291 | 99292 | 99305 | 99306 | 99307 | 99308 | 99309 |
| 99310 | 99315 | 99316 | 99334 | 99335 | 99336 | 99337 | 99347 | 99348 | 99349 | 99350 | 99374 | 99375 | 99376 | 99378 |
| G0463 |
| 57555-May Be Paid                                                                 |
| 0213T | 0216T | 0228T | 0230T | 51701 | 51702 | 51703 | 57000 | 57100 | 57150 | 57180 | 57410 | 57420 | 57452 | 57500 |
| 57530 | 57800 | 58100 | 62310 | 62311 | 62318 | 62319 | 64400 | 64402 | 64405 | 64406 | 64410 | 64412 | 64413 | 64415 |
| 64416 | 64417 | 64418 | 64420 | 64421 | 64425 | 64430 | 64435 | 64445 | 64446 | 64447 | 64448 | 64449 | 64450 | 64459 |
| 64483 | 64486 | 64487 | 64488 | 64489 | 64490 | 64493 | 64505 | 64508 | 64510 | 64517 | 64520 | 64530 | 69990 | 99148 |
| 99149 | 99150 | 99446 | 99447 | 99448 | 99449 | 99495 | 99496 | G0471 | G0612 |
| Never Paid                                                                                   |
| 12001 | 12002 | 12004 | 12005 | 12006 | 12007 | 12011 | 12013 | 12014 | 12015 | 12016 | 12017 | 12018 | 12020 | 12021 |
| 12031 | 12032 | 12034 | 12035 | 12036 | 12037 | 12041 | 12042 | 12044 | 12045 | 12046 | 12047 | 12051 | 12052 | 12053 |
| 12054 | 12055 | 12056 | 12057 | 13100 | 13101 | 13102 | 13120 | 13121 | 13122 | 13131 | 13132 | 13133 | 13151 | 13152 |
| 13153 | 36000 | 36400 | 36405 | 36406 | 36410 | 36420 | 36425 | 36430 | 36440 | 36600 | 36640 | 37202 | 43752 | 50715 |
| 52000 | 57105 | 57200 | 57210 | 57421 | 57522 | 57545 | 92012 | 92014 | 93000 | 93005 | 93010 | 93040 | 93041 | 93042 |
| 93318 | 93355 | 94002 | 94200 | 94250 | 94680 | 94681 | 94690 | 94770 | 95812 | 95813 | 95816 | 95819 | 95822 | 95829 |
| 95955 | 96360 | 96365 | 96372 | 96374 | 96375 | 96376 | 99211 | 99212 | 99213 | 99214 | 99215 | 99217 | 99218 | 99219 |
| 99220 | 99221 | 99222 | 99223 | 99231 | 99232 | 99233 | 99234 | 99235 | 99236 | 99238 | 99239 | 99241 | 99242 | 99243 |
| 99244 | 99245 | 99251 | 99252 | 99253 | 99254 | 99255 | 99256 | 99291 | 99292 | 99305 | 99306 | 99307 | 99308 | 99309 |
| 99310 | 99315 | 99316 | 99334 | 99335 | 99336 | 99337 | 99347 | 99348 | 99349 | 99350 | 99374 | 99375 | 99376 | 99378 |
| G0463 |

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For code 57550, the bundles are as follows:

**57550-May Be Paid.** The codes in the right hand column are code pairs (either component or mutually exclusive codes) that are considered bundled into comprehensive code 57550. In some instances, and with an appropriate modifier, these codes may be payable when performed on the same date as 57550.

**Never Paid.** The codes in the right hand column are code pairs (either component or mutually exclusive codes) that will never be reimbursed by Medicare when performed on the same date as 57550 even if a modifier is used.

Not all comprehensive codes will include a listing of codes that may be payable with a modifier ("May Be Paid") and codes that will never be paid ("Never Paid").

Physicians should check the chart for each code being billed to Medicare to determine if the procedures are bundled.