NCCI Update: What's New in NCCI?

A LIVE VIRTUAL EVENT PRESENTED ON JANUARY 20, 2022

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Presented By

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Identify the three different types of NCCI edits
  - Determine if a modifier is appropriate on Procedure to Procedure edits
  - Review of medically unlikely edit rationale
  - Application of add on code edits
  - Identify revisions to the NCCI manual effective 1/1/2022

National Correct Coding Initiative

- The NCCI is a CMS initiative intended “to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.”
  - Maintained by a CMS contractor – currently noted as ‘NCCI Contractor’ on the CMS website
    - All correspondence with contractor to be funneled through central CMS email address
  - Applies only to Medicare Part B claims – it does not apply to hospital inpatient services or any other services covered under Medicare Part A

National Correct Coding Initiative

- Edits are developed based on
  - CPT and HCPCS Manual code descriptors
  - Coding conventions defined in the CPT Manual
  - Coding guidelines developed by national societies
  - Analysis of standard medical and surgical practice
  - Review of current coding practice
  - Provider billing patterns

<NCCI Policy Manual, Introduction>

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National Correct Coding Initiative

- The NCCI manual contains both correct coding policies and correct coding edits
- The NCCI policy manual and edits may be downloaded from the CMS web site at
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

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National Correct Coding Initiative

- Composition of the NCCI Edits
  - The NCCI consists of three types of edits:
    - Procedure to Procedure (PTP) edits
    - Medically Unlikely Edits (MUEs)
    - Add-on Code Edits

<NCCI Policy Manual, Introduction>

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National Correct Coding Initiative

- Procedure to Procedure (PTP) edits
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
  - Files for OP Hospital and Practitioner – be sure to choose correct files!
  - PTP edits are pairs of CPT or HCPCS Level II codes that are not both separately payable when billed by the same provider for the same beneficiary for the same date of service, unless an appropriate modifier is reported
  - Edits are identified in a Column1/Column2 format available in two files posted on the CMS website
    - Formerly known as “comprehensive/component” edits

<CMS Frequently Asked Question 11238; NCCI Policy Manual, Introduction>

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National Correct Coding Initiative

- For each Column 1/Column 2 Edit, the column 1 code generally has a higher payment rate than the column 2 code
  - This means CMS pays for the code with the higher payment amount if the two codes are reported together
  - Edits are generally designed to prevent unbundling
    - In other words, separate payment for a service that is considered to be a lesser included component of another more comprehensive service provided at the same session
- In some instances, column 1 has a lower payment rate
  - These are mutually exclusive edits – cannot reasonably be done/reported in the same session
    - e.g. 10060 (I&D) & 11401 (excision) – if performed on same site, not allowed on same day

<CMS Frequently Asked Question 11238; NCCI Policy Manual, Introduction>

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National Correct Coding Initiative
PTP Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
26020	26170		19970401	20061231	1	CPT "separate procedure" definition
26020	26185		19980101	*	1	CPT "separate procedure" definition

- Column 1 indicates the payable code
- Column 2 contains the code that is not payable with this particular Column 1 code, unless a modifier is permitted and submitted
- The third column indicates if the edit was in existence prior to 1996
- The fourth column indicates the effective date of the edit (year, month, date)
- The fifth column indicates the deletion date of the edit (year, month, date)
- The sixth column contains a correct coding modifier (CCM) indicator which indicates if a modifier is permitted
- The seventh column provides the underlying basis for each PTP edit

<HOW TO USE THE MEDICARE NATIONAL CORRECT CODING INITIATIVE (NCCI) TOOLS p5>

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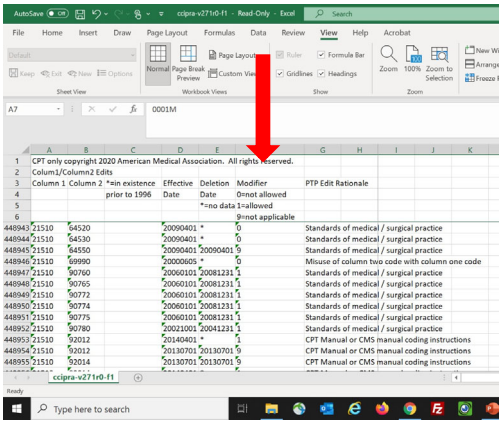
National Correct Coding Initiative

- Modifiers Applied to Procedure to Procedure Edits
  - A "modifier" status indicator is assigned to each set of PTP code pairs:
    - Status indicator **1** (allowed)
      - the edit may be overridden by reporting one of the NCCI-associated modifiers on the column 2 code
      - Must use a modifier- if the column 2 code is reported without a modifier, the column 2 code will deny
    - Status indicator **0** (not allowed)
      - No modifier can override the CCI edit
      - If the column 2 code is reported with or without a modifier, the column 2 code will deny
    - Status indicator **9** (not applicable)
      - the edit has been removed from the NCCI and is displayed for historical purposes



<NCCI Policy Manual, Chapter 1 (E)>

National Correct Coding Initiative

- NCCI-Associated Modifiers - According to CMS, the following modifiers will override an NCCI PTP edit:
  - -E1 through -E4 – eyelids
  - -FA through -F9 – fingers
  - -LC, -LD, -LM and –RC, -RI - arteries
  - -LT and -RT – left and right sides
  - -TA through -T9 – toes
  - -XE – Separate encounter
  - -XS – Separate structure
  - -XP – Separate practitioner
  - -XU – Unusual non-overlapping service
  - -24 – unrelated E/M service during post-op period
  - -25 – significant, separately identifiable E/M service
  - -27 – separate and distinct E/M encounter (applicable to outpatient hospital facilities)
  - -57 – decision for surgery
  - -58 – staged or related procedure
  - -59 – distinct procedural services
  - -78 – related procedure
  - -79 – unrelated procedure or service
  - -91 – repeat lab test

<NCCI Policy Manual, Chapter 1 (E)>

National Correct Coding Initiative
PTP Edits

- Example: A patient presents to the urgent care center for treatment after falling from a tree. The patient suffered a 17cm laceration to the left arm and a deep abrasion to the left knee with residual debris. The provider determined the laceration required intermediate closure (12035). The patient also required debridement of the skin on the knee (not requiring closure) measuring 10 cm (97597) during this encounter.

- According to the PTP Edit, how should this be coded?

Column 1	Column 2	Modifier Status Indicator
12035	97597	1

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Test Your Knowledge #1 – PTP Edits

- Example: A patient presented to the urgent care center for treatment after falling from a tree. The patient suffered a 17cm laceration to the left arm and a deep abrasion to the left knee with residual debris. The provider determined the laceration required intermediate closure (12035). The patient also required debridement of the skin on the knee (not requiring closure) measuring 10 cm (97597).

- According to the PTP Edit, how would this be coded?

Column 1	Column 2	Modifier Status Indicator
12035	97597	1

  - **Answer:** 12035, 97597 -59 (or -XS)

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Test Your Knowledge #2 – PTP Edits

Penny Fisher, an established Medicare patient, presented to Dr. Welby for a scheduled diagnostic bronchoscopy procedure (31622). Prior to the procedure, the provider documents the routine pre-procedural history, exam and medical decision making for an office visit (99213). The following Procedure to Procedure NCCI edit applies:

Column 1	Column 2	Modifier Status Indicator
31622	99213	1

How should Dr. Welby's services be reported?

a. 99213
b. 31622, 99213-25
c. 31622, 99213-59
d. 31622

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Test Your Knowledge #2 – PTP Edits

Penny Fisher, an established Medicare patient, presented to Dr. Welby for a scheduled diagnostic bronchoscopy procedure (31622). Prior to the procedure, the provider documents the routine pre-procedural history, exam and medical decision making for an office visit (99213). The following Procedure to Procedure NCCI edit applies:

Column 1	Column 2	Modifier Status Indicator
31622	99213	1

How should Dr. Welby's services be reported?

a. 99213
b. 31622, 99213-25
c. 31622, 99213-59
d. 31622

Modifier-25 may only be appended when the pre/post op service is above and beyond the expected

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National Correct Coding Initiative

- Medically Unlikely Edits (MUEs)
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
  - Represent the maximum number of units reportable for a HCPCS code by the same provider for the same beneficiary for the same date of service, in most circumstances
  - CMS published an MUE file containing the MUE limits for some, but not all HCPCS codes.
    - Separate files for practitioner, facility, and DME services
      - Updated quarterly

<NCCI Policy Manual, Chapter 1 (V); One Time Notification Transmittal 652>

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National Correct Coding Initiative

- The MUE file contains a column with the rationale for each of the MUEs based on the following considerations:
  - Anatomic considerations (e.g. appendectomy)
  - Code descriptions (e.g. a code with the term “initial” in its title)
  - Established CMS policy (e.g. bilateral procedures)
  - Nature of the analyte (e.g. 24 hour urine collection)
  - Nature of the procedure and the amount of time required to perform the procedure (e.g. overnight sleep study)
  - Nature of the item (e.g. wheelchair)
  - Clinical judgment based on input from physicians and clinical coders
  - Submitted claims data from a 6 month period

<NCCI Manual, Chapter 1(V)>

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National Correct Coding Initiative - MUEs

HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
90460	9	3 Date of Service Edit: Clinical	Clinical: Society Comment
90461	8	3 Date of Service Edit: Clinical	Clinical: Society Comment
90471	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
90472	8	3 Date of Service Edit: Clinical	Clinical: Society Comment

- The MUE file contains a column indicating whether an MUE will be applied by date of service or by claim line
  - MUEs Applied by DOS (MAI's of 2 or 3)
    - All claim lines with the same HCPCS code, regardless of modifier, on the same date of service will be summed and compared to the MUE value
      - The claim will be denied if the units summed in this way exceed the MUE value
    - CMS has assigned one of 2 MUE Adjudication Indicators (MAI) for DOS MUEs
      - **2**: indicates that the edit is based on regulation, policy, or instruction that is inherent in the code descriptor or its applicable anatomy – *CMS Contractors are bound by these!*
      - **3**: indicates that the edit is based on clinical information, billing patterns, prescribing instructions, and other information – *If coded properly, providers can appeal claims!*

<CMS FAQ 8119; MLN Matters Article SE 1422>

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National Correct Coding Initiative – MAI of 1

- MAI of 1 - Line Item Edit (not DOS)
- Medically appropriate units of service in excess of an MUE
  - Reported on a separate line with an appropriate modifier – will process for payment
  - Use only when medical necessity is met
- Only 41 codes with MAI of 1

HCPCS Code	MUE Value	MAI	MUE Rationale
99486	4	1 Line Edit	Clinical: CMS Workgroup
A0425	250	1 Line Edit	Clinical: Data
A6460	1	1 Line Edit	Clinical: CMS Workgroup
A6461	1	1 Line Edit	Clinical: CMS Workgroup
C2644	500	1 Line Edit	Prescribing Information
G0514	1	1 Line Edit	Clinical: CMS Workgroup
J3471	999	1 Line Edit	Code Descriptor / CPT Instruction
J7175	9000	1 Line Edit	Prescribing Information
J7178	7700	1 Line Edit	Prescribing Information
J7179	7500	1 Line Edit	Clinical: CMS Workgroup
J7180	6000	1 Line Edit	Prescribing Information
J7181	3850	1 Line Edit	Clinical: CMS Workgroup
J7182	22000	1 Line Edit	Clinical: Data
J7183	7500	1 Line Edit	Clinical: CMS Workgroup

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Test Your Knowledge #3 – MUEs

- Example: A psychotherapist meets with the family members of a patient to discuss therapy goals without the patient present for 90 minutes (90846- Family psychotherapy, 50 minutes). Using the MUE table below, how should the provider bill for the service provided?

a) 90846 x2
b) 90846
c) Cannot bill for this service
d) 90846, 90846-59

HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
90846	1	3 Date of Service Edit: Clinical	CMS Policy

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Test Your Knowledge #3 – MUEs

- Example: A psychotherapist meets with the family members of a patient to discuss therapy goals without the patient present for 90 minutes (90846- Family psychotherapy, 50 minutes). Using the MUE table below, how should the provider bill for the service provided?

a) 90846 x2
b) 90846
c) Cannot bill for this service
d) 90846, 90846-59

HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
90846	1	3 Date of Service Edit: Clinical	CMS Policy

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National Correct Coding Initiative

- Add-on Code Edits
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html

  – Describes a service that is always performed in conjunction with another primary service and is eligible for payment only when provided with an appropriate primary service
    - If an add-on code is reported without the required primary procedure code, the add-on code may not be paid

<Medicare Claims Processing Manual Transmittal 2636>

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National Correct Coding Initiative

- Identified Add-on Codes:
  – Type I- have a limited number of identifiable primary codes

+ 11008 Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)
CPT Changes: An Insider's View 2005, 2008
CPT Assistant Jan 12:6, Oct 12:3
(Use 11008 in conjunction with 10180, 11004-11006)

  – Type II- do not have a list of acceptable primary codes
    - Claims processing contractors are encouraged to develop their own lists of primary procedure codes for these types of add-on codes

+ 44955 when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)

<Medicare Claims Processing Manual Transmittal 2636>

Source: 2022 AMA CPT

National Correct Coding Initiative

- Identified Add-on Codes:
  - Type III- have some, but not all, of the acceptable primary codes identified
    - Claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary procedure codes for add-on codes in this Type
    - Example: Acceptable primary codes 64702-64726 plus Contractor Defined Primary Code(s)

+ 64727 Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

Source: 2022 AMA CPT

<Medicare Claims Processing Manual Transmittal 2636>

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Test Your Knowledge #4 – NCCI

Benny Fisher presented to the hospital outpatient surgical department for neuroplasty to treat carpal tunnel syndrome (CPT code 64721 – neuroplasty and/or transposition median nerve at carpal tunnel). During the procedure the surgeon performed neurolysis using the operating microscope (CPT code 64727 – Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990. The following Procedure to Procedure & Add-on edits apply:

PTP - Column 1	Column 2	Modifier Status Indicator
64727	69990	0

Add-on Code	Primary Code (s)
64727	64702-64726 ("List separately in addition to the code for neuroplasty") plus possibly other primary codes

How should the surgeon report these surgical services?

a. 64727, 69990
b. 64721, 64727
c. 64721, 64727-51
d. 64721, 64727, 69990

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Test Your Knowledge

Benny Fisher presented to the hospital outpatient surgical department for neuroplasty to treat carpal tunnel syndrome (CPT code 64721 – neuroplasty and/or transposition median nerve at carpal tunnel). During the procedure the surgeon performed neurolysis using the operating microscope (CPT code 64727 – Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990. The following Procedure to Procedure & Add-on edits apply:

PTP - Column 1	Column 2	Modifier Status Indicator
64727	69990	0

Add-on Code	Primary Code (s)
64727	64702-64726 ("List separately in addition to the code for neuroplasty") plus possibly other primary codes

How should the surgeon report these surgical services?

a. 64727, 69990

b. 64721, +64727

c. 64721, +64727-51

d. 64721, +64727, 69990

(Do not report code 69990 in addition to code 64727)

Source: 2022 AMA CPT

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NCCI Manual Updates – Effective 1/1/2022

NCCI – Introduction

- Clarified Add-On code edits:
  - "Are performed in conjunction with another primary service by the same practitioner."
  - "An Add-on code is **rarely** eligible for payment if it is the only procedure reported by a practitioner."

- Added "suppliers"
  - To all citations referring to "providers" the term "**suppliers**" was added
  - This change was made throughout all Chapters.

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NCCI – Chapter 1 - General

- Providers/suppliers shall only report a biopsy separately when pathologic examination results in a **decision to immediately proceed with a more extensive procedure** (e.g., excision, destruction, removal) on the same lesion; or when performed on a separate lesion.

- Providers/suppliers shall **not** report a biopsy separately when it is **to assess resection margins or to verify resectability**; or when performed and **submitted for pathologic evaluation completed after performing the more extensive procedure.**

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NCCI- Chapter 1 - General

- Anesthesia Service Included in the Surgical Procedure
  - * Also added to Chapter 2*
  - Under the CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. Likewise, under OPPS, payment for the anesthesia service is generally included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

CPT Surgical Package Definition

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia

Source: 2022 AMA CPT

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NCCI – Chapter 3 - Integumentary

- Lesion removal
  - If **it is medically necessary to remove multiple lesions separately**, it may be appropriate (depending upon the code descriptors) for the procedures to report multiple HCPCS/CPT codes using anatomic modifiers or modifier 59 or XS to indicate different sites or lesions.

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less

Source: 2022 AMA CPT

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NCCI – Chapter 4 -- Musculoskeletal

- When reporting manual therapy techniques (e.g., CPT code 97140) in the anatomic region where a multi-layer compression system (e.g., CPT codes 29581-29584) is applied, it may be necessary to indicate that the manual therapy techniques are distinct from the multi-layer compression system application, modifier 59 or – X{EPSU} may be appended to either column code.

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NCCI- Chapter 5 – Respiratory, Cardiovascular, Lymphatic

- Dialysis Circuit
  - CPT codes 36901-36906 describe progressively more intensive services.
  - Report only one code from this range for services provided in a dialysis circuit. CPT codes 36907 and 36908 are add-on codes reported with 36901-36906 as appropriate. These codes may only be reported once per session regardless of the number of lesions treated. CPT 36909 is an add-on code reported with 36901-36906 as appropriate and describes endovascular embolization or occlusion and may be reported only once per session regardless of the number of branches embolized or occluded.

Codes 36901, 36902, 36903 and 36904, 36905, 36906 are built on progressive hierarchies that have more intensive services, which include less intensive services. Report only one code (36901, 36902, 36903, 36904, 36905, 36906) for services provided in a dialysis circuit.

Source: 2022 AMA CPT

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NCCI – Chapter 7 – Urinary/Genital/OB

- Female Genital System procedures
  - Dilation of vagina or cervix (CPT codes 57400 or 57800) are generally not reportable in conjunction with vaginal approach procedures.
    - Leaving that small possibility as an "out". ☺

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NCCI – Chapter 9 - Radiology

- Modifier -59 shall **not** be used with code 77427 (Radiation treatment management, 5 treatments)

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NCCI – Chapter 10 – Pathology/Laboratory

- Defined "**reflex tests**"
  - Some laboratory test results typically require separate follow-up testing which is implicit in the physician's order.
    - For example, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable.
    - The initial results have limited clinical value without the separate follow-up test.
- **Non-reflex tests** (i.e., the physician's initial order does not implicitly include additional testing)
  - The physician must order additional testing.

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NCCI – Chapter 10 – Pathology/Laboratory

- New Clinical Pathology Consultation Codes (CPT codes 80503-80506)
  - Reporting of these services may be based on either the **total time** for pathology clinical consultation services performed on the date of consultation **or level of medical decision making.**

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National Correct Coding Initiative

- Practical NCCI Issues
  - Do Not Count on the CMS System to Serve as Your "Claims Scrubber"
    - CMS claims processing systems should reject or deny lines or claims that do not conform to NCCI edits, however if the claims system fails and the MAC pays for a service in contradiction to an NCCI edit, the provider may be required to make a repayment
  - Use of Correct Coding Modifiers Should Not Be Used to Override an NCCI Edit
    - Modifiers should only be used in a clinically appropriate manner in accordance with CPT and CMS guidelines for modifier usage
    - Inappropriate use of modifiers could result in an overpayment subjecting the practitioner to an overpayment demand, a false claims action, or worse
  - The NCCI Policy Manual should be used in conjunction with the CCI Edit Tables

<NCCI Policy Manual, Introduction>

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Summary

Just Because a NCCI Edit is ALLOWED
Does Not Make it Appropriate
In Every Situation – Know the Reason

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Thank you for your time! Questions?

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