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Dermatology Coding Alert

CCI Primer: 4 FAQs Spotlight Bundling Rules for Dermatological Surgeons

Know when modifiers, ABNs can't override edit pairs.

Keeping abreast of Medicare's Correct Coding Initiative (CCI) quarterly updates is good. But that's not all you need to know about CCI to avoid pitfalls and seize opportunities for your dermatology practice.

Use the following four frequently asked questions about CCI to help you focus your bundling/unbundling skills for clean claims and maximum correct pay.

FAQ 1: Merge Edit Tables

Question: I've heard there are two CCI edit tables. What's the difference, and how can I be sure I'm seeing edits from both tables?

Answer: You're correct that CCI had two edit tables one for "Mutually Exclusive" edits and one for "Column 1/Column 2" edits but no longer. Beginning April 1, 2012, CMS merged the two tables into a single paired-code edit table.

Now, if you go to the CCI website (www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html), you don't have to download and research two separate tables to look for a code pair in a specific numeric range. According to CMS, "all active and deleted edits [now] appear in the single Column One/Column Two Correct Coding edit file."

Don't miss: "The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file," CMS states.

FAQ 2: Refine Your Modifier Skills

Question: Our billing company says that we can never bill together 11043 and 11042, because doing so would be ignoring a CCI edit. But in one claim, our surgeon performed debridement on two different areas of the foot, so we're wondering if the billing company is correct.

Answer: In certain clinical circumstances you can override not ignore some CCI edits and receive separate payment for bundled codes, such as 11042 (Debridement, subcutaneous tissue [includes epidermis and dermis, if performed]; first 20 sq. cm or less) and 11043 (Debridement, muscle and/or fascia [includes epidermis, dermis, and subcutaneous tissue, if performed]; first 20 sq. cm or less).

To find out if you can separately bill services, first check the "modifier indicator" in column F of the CCI spreadsheet.

A "0" indicator means that you cannot unbundle the two codes under any circumstances, says **Chandra L. Hines**, practice supervisor of Wake Specialty Physicians in Raleigh, NC. An indicator of "1," however, means that you may use a modifier to override the edit if the clinical circumstances warrant separate payment, she adds.

Tip: Surgeons may override an edit pair using anatomic modifiers such as T3 (Left foot fourth digit) or a more general modifier when a specific modifier is not available, such as 59 (Distinct procedural service). But you should only use the modifier under specific clinical circumstances, such as when the surgeon treats the patient during a different session, or at a different site/organ system, or makes a separate incision/excision, or tends to a different lesion/injury.

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Codes 11042 and 11043 serve as a good example. If the surgeon debrides one area, first debriding to the subcutaneous tissue, then proceeding deeper at the same site to the muscle, you should not report both 11042 and 11043. On the other hand, if the surgeon performs debridement to the different depths at two different sites, you can override the CCI edit by appending the appropriate modifier to 11042.

FAQ 3: Check Payers

Question: When we're billing a payer other than Medicare Part B, do we have to follow CCI edits, or are they Medicare-specific?

Answer: Although all Medicare Part B payers follow the CCI edits, many other payers take them into account when determining which procedures should be paid separately, Hines says.

Example: As part of the Affordable Care Act, state Medicaid programs were told to begin using CCI edits when processing claims as of Oct. 1, 2010. This means that you've probably seen CCI edits at work with some of your Medicaid claims. In addition, many private payers and workers' compensation insurers also use the CCI to justify claims payment and denials. You should check with your payers to determine which use the CCI edits and which do not.

FAQ 4: Save Your ABNs

Question: What's the difference between a "medically unlikely edit" and a "CCI edit?" When we know that a charge will be denied due to these edits, can we get a signed an advance beneficiary notification (ABN) and bill the patient?

Answer: CCI edits relate to code pairings (whether two codes can be billed together), says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPCP, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. MUEs refer to a single code and limit the number of times on a date of service that you can bill a particular code, she adds.

Regarding ABNs, the answer is, no, you shouldn't balance bill a patient when you bill two codes together and one is denied because the codes are bundled by CCI edits. Because CMS considers the two bundled procedures not medically necessary, you can't pass the cost on to the patient.

The same is true for MUEs. Even if you have the patient sign an ABN, you cannot pass on the cost of procedures you know will be denied due to MUEs, Cobuzzi warns.

CMS makes this rule very clear in its FAQs, stating: "A provider/supplier may not issue an ABN for units of service in excess of an MUE. Furthermore, if services are denied based on an MUE, an ABN cannot be used to shift liability and bill the beneficiary for the denied services. It is a provider/ supplier liability."

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