

Internal Medicine Coding Alert

CCI 17.0: Newest CCI Edits Include More Procedures Related to "Guidance"

Don't submit 77001 or 77002 with fracture care, TPI, arthrocentesis

The newest edition of Correct Coding Initiative edits (CCI 17.0) went into effect Jan. 1, 2011, and clarifies that common services such as trigger point injections and fracture care include fluoroscopic guidance.

Nix Fluoroscopic Guidance for Common Procedures

Non-mutually exclusive edits apply to services that an internist might perform during the same care session but that aren't billable together. This is because one of the codes (the component code) is included in the services represented by the first (comprehensive) code of the pairing. You can bill individual components if the physician does not perform the entire comprehensive procedure. But if the physician performs the entire (comprehensive) procedure, you should bill the comprehensive code instead of the individual parts or components.

CCI 17.0 includes non-mutually exclusive edits for several common procedures performed with fluoroscopic guidance. The guidance procedures in question include:

- +77001 -- Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)
- 77002 -- Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device).

According to CCI 17.0, you shouldn't report +77001 or 77002 when your internist administers trigger point injections (20552 or 20553), completes arthrocentesis, aspiration and/or injection of a joint or bursa (20600, 20605, or 20610), drains a simple finger abscess (26010), or performs closed treatment of a distal radial fracture (25600). Instead, just report the procedure itself.

Exceptions: Each edit pair carries a modifier indicator of "1," meaning you can sometimes bypass the edit by filing your claim with an appropriate modifier. Be sure you have enough supporting documentation to justify payment for both codes before filing with a modifier such as 59 (Distinct procedural service). For example, documentation could include notes that indicate the provider used guidance on a different site than where the procedure was performed, or for some reason separate from the main procedure.

Forget Subsequent Observation Care With Developmental Testing

CPT 2011 introduces three new codes for subsequent observation care (99224-99226, Subsequent observation care, per day, for the evaluation and management of a patient ...). CCI 17.0 notes that extended developmental testing (96111, Developmental testing; extended [includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments] with interpretation and report) include services represented by 99224-99226. The edits do carry a modifier indicator of "1," however, so you can unbundle the pairs and report both codes in some situations.

Services covered by 99455 (Work related or medical disability examination by the treating physician ...) also include any care represented by 99224-99226. These edits carry a modifier indicator of "0," which means you cannot report the services with a modifier to try and be paid for both codes. If you submit both codes on the same claim, you'll receive an

automatic denial.

FYI: CCI 17.0 includes 698,042 active edit pairs, according to an analysis by **Frank Cohen, MPA, MBB**, senior analyst for The Frank Cohen Group in Clearwater, Fla. Check the latest version at <http://www.cms.gov/NationalCorrectCodInitEd/> to ensure you correctly report procedures.