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Part B Insider (Multispecialty) Coding Alert

CCI 19.0: Latest CCI Edition Targets New CPT Codes

Most specialties under scrutiny with the new edition of CCI.

With the new year comes new CPT codes -- and unfortunately, new Correct Coding Initiative (CCI) edits. CCI 19.0, which took effect on January 1, 2013, adds 37,587 new bundles and deletes 16,716. Not surprisingly, many of the recent CCI edits target new 2013 CPT® codes. We've got a sampling of how this impacts several specialties.

Urology: Avoid Billing 52287 With 52281

You will find new Botox bladder injection CPT® code 52287 (Cystourethroscopy with injection[s] for chemodenervation of the bladder) bundled into column 1 code 52281 (Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female). This edit pair has a modifier indicator of "0." That means you cannot undo the bundle with any modifier. In other words, these two procedures can never be reported or reimbursed if performed at the same operative encounter or even on the same day but at different sessions.

Additionally: CCI 19.0 also bundles the following column 2 codes into 52287:

Anesthesia 00910 and 00916

Category III codes 0213T, 0216T, and 0230T

Wound closure codes 12001-12053

Intravenous codes 36000, 36405, 36410, 36420-36430, 36600, 36640

Catheterization codes 51701-51703

Cystoscopic codes 52000, 52001, 52310, 52315

Urethrotomy and meatotomy codes 53000-53025

Urethral dilation codes 53600-53665,

Pelvic exam under anesthesia code 57410.

All of these noted edit pairs have a modifier indicator of "0," except the wound closure codes, intravenous and venous codes, and 52001 (Cystourethroscopy and evacuation of multiple obstructing clots), which all have a modifier indicator of "1." That means that you can use a modifier to override the bundling under specific clinical circumstances.

Anesthesia: Say Farewell to Reporting Anesthesia With Needle EMGs

The majority of anesthesia edits fall into the category of "CPT® manual or CMS manual coding instructions." For example, codes 00210-00222 (Anesthesia for intracranial procedures ...) should be reported instead of a wide range of associated procedures, including:

92585 -- Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

95860 -- Needle electromyography; 1 extremity with or without related paraspinal areas

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95910 -- Nerve conduction studies; 7-8 studies

95940 -- Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure).

Many of the same secondary (column 2) codes for edit pairs carry throughout the anesthesia code section of CPT® 2013. All edits that are justified through CPT® or CMS instructions carry a modifier indicator of "0," meaning you cannot append a modifier and submit documentation to be paid for both portions of the procedure.

Other anesthesia edits are in effect because of "Standard preparation/monitoring services for anesthesia." The anesthesia code is listed first in all these edit pairs, meaning it overrides the other code in the pair.

Example: Edits that apply because anesthesia administration is a standard part of the procedure include 01470 (Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified) with 0311T (Non-invasive calculation and analysis of central arterial pressure waveforms with interpretation and report), 31647 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve[s], initial lobe), and 99485 (Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes).

CCI 19.0 lists the same three secondary codes -- 0311T, 31647, and 99485 -- as Column 2 codes for procedures throughout CPT®'s anesthesia section.

Don't Get Excited Over Deleted Edits: CCI 19.0 includes more than 16,000 deleted edits, with virtually every anesthesia code affected by one change. Non-mutually exclusive edits for anesthesia services with 0251T (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve[s], initial lobe) have been deleted.

Caution: Don't start counting the extra money your practice will earn for billing anesthesia services during bronchoscopy. Codes 0250T-0252T have been deleted from CPT® 2013, which explains the change in edits. New codes 31647-31649 are one-to-one replacements for the previous T codes.

Crosswalk tip: Codes 31647 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve[s], initial lobe) and 31648 (... with removal of bronchial valve[s], initial lobe) each cross to anesthesia code 00520 (Anesthesia for closed chest procedures; [including bronchoscopy] not otherwise specified).

Oncology: Breast Biopsy Can't Be Reported with 77051

Thanks to CCI, you cannot report a breast biopsy and a mammogram to confirm clip placement.

Scenario: The physician performs a breast biopsy and places a metallic localization clip, using radiologic guidance. The patient then has a mammogram at the same encounter to confirm placement. Should you report the mammogram for payers who apply Medicare rules?

Solution: No, you should not report the mammogram in this case. According to the updated manual, "The radiologic guidance codes include all imaging required to perform the procedure."

More specifically, "If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with radiologic guidance (e.g., 76942, 77012, 77021, 77031, 77032), the physician should not separately report a post procedure mammography code (e.g., 77051, 77052, 77055-77057, G0202-G0206) for the same patient encounter," states Chapter IX, Section D.11, of the manual.

Resource: To review the revised manual, head to www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html. The CCI policy manual is available from the Downloads section.

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