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Part B Insider (Multispecialty) Coding Alert

National Correct Coding Initiative: Master NCCI PTP Edit Pair Guidelines with Expert Advice

Know how 0, 1, and 9 add up to total coding success.

Maybe you're grappling with the latest update of the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edit pairs - or pondering why Medicare produces this comprehensive listing in the first place.

If you're contemplating these quandaries and others, you aren't alone. Check out this FAQ to answer those questions and boost your CPT® coding accuracy.

What Are the NCCI Edits?

The NCCI edits are "a national standard for ensuring proper payment and coding. The goal was to set a methodology that would identify unbundling and over-coding scenarios," according to **Chelle Johnson, CPMA, CPC, CPCO, CPPM, CEMC**, AAPC Fellow, billing/credentialing/auditing/coding coordinator at County of Stanislaus Health Services Agency in Modesto, California.

The purpose "is to prevent improper payment when incorrect code combinations are reported" by assembling "code pairs that should not be reported together for a number of reasons," explains the Centers for Medicare & Medicaid Services (CMS) in NCCI guidance.

See more details at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd.

What Are Edit Pairs?

CMS creates an edit pair when it regards a specific service as being a component part of a larger, more comprehensive service using the following general guidelines, according to the NCCI Policy Manual for Medicare Services:

1. "The component service is an accepted standard of care when performing the comprehensive service.

2. "The component service is usually necessary to complete the comprehensive service.

3. "The component service is not a separately distinguishable procedure when performed with the comprehensive service."

Find the NCCI Policy Manual for Medicare Services at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.

Example: CMS regards the immunization administration with counseling codes 90460 (Immunization administration …) and +90461 (… each additional vaccine or toxoid component administered …) as comprehensive services that include sick visit codes 99201-99215 (Office or other outpatient visit for the evaluation and management of a new/established patient …) as a component service. So, 99201-99215 are considered bundled into the 90460/+90461 services, and the codes are considered an edit pair.

What Is an MUE?

In addition to PTP edit pairs, "CMS has created Medically Unlikely Edits, or MUEs, to reduce coding errors and fraud," explains **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania. "MUEs represent the maximum number of times one service can be performed on one patient and are usually determined by such biological factors as how many organs or limbs typically exist in the human anatomy, or whether the service is

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gender-specific. They are CMS' way of deciding how many units you can bill on one service line," Falbo further elaborates.

Example: As humans only have one appendix that can only be removed once, CMS gives the code for removing the body part - 44970 (Laparoscopy, surgical, appendectomy) - an MUE unit of 1 to show that the procedure can only be performed one time on the same patient.

How Do the Edits Work?

CMS assigns Column 1 status to the comprehensive service and Column 2 status to a code they regard as being a component part of the Column 1 service.

CMS then assigns one of three modifier indicators to each edit pair. An indicator of 0 means that the pair cannot be unbundled with an NCCI-associated modifier and that only Column 1 procedures will be paid in claims featuring both services. An indicator of 1 means that both services may be reported together if an NCCI-associated modifier is appended to the Column 2 code and both services are eligible for payment. An indicator of 9 means the pair has been deleted, and that you can ignore the indicator.

What Are NCCI-Associated Modifiers?

NCCI-associated modifiers "allow for certain CPT® codes to be billed together when they are medically appropriate and when the documentation supports the allowance of both CPT® codes. Normally, the CPT® codes would be considered inclusive and denied as unbundled," explains Johnson.

Depending on the circumstances, you can use one of the following modifiers to unbundle an edit pair:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI

Global surgery modifiers: 24, 25, 57, 58, 78, 79

Other modifiers: 27, 59, 91, XE, XS, XP, XU

What Else Should I Know About the NCCI Edits?

"You should have an in-depth knowledge of the procedure as well as anatomy to know when a NCCI-associated modifier should be allowed," suggests Johnson. "This is especially true when it comes to the proper use of modifier 59 [Distinct procedural service]," adds Falbo.

Tip: To use modifier 59 correctly, you should make sure that your documentation supports "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury …) not ordinarily encountered or performed on the same day by the same individual," advises MLN Matters SE 1418.

Plus, modifier 59 should be the best modifier choice to explain the circumstances, explains CMS in its guidance.

This means you should only use modifier 59 if "no more descriptive modifier is available" and when the service being modified is not an E/M [evaluation and management] service," according to CMS. For that, you should append modifier 25 (Significant, separately identifiable evaluation and management service …).

Review MLN Matters SE 1418 at
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf.

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