Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: CCI Takes Aim at Urology Codes

Good news: Most new edit pairs will allow a modifier.

Round three of the 2014 Correct Coding Initiative (CCI) edits bring several bundles that you need to watch out for or you'll face denials on your urology claims. CCI version 20.2 took effect on July 1, 2014, and our experts have scoured the changes to give you this rundown of the edits your urology practices needs to learn.

Watch for Skin Excision Additions

You will find that CCI 20.2 makes column 1 codes 17000 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesions [e.g., actinic keratoses]; first lesion) and 17004 (... 15 or more lesions) mutually exclusive with column 2 codes 17270-17276 (Destruction, malignant lesion [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], scalp, neck, hands, feet, genitalia ...).

Additionally, 17004 is mutually exclusive with the following column 2 codes:

- 11305-11308 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia ...)
- 11420-11426 (Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia ...)
- 11620-11626 (Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia ...).

"All these edits have a modifier indicator of "1," which means that you can override the bundle between these codes using a modifier, such as modifier 59 (Distinct procedural service), in certain clinical circumstances," says Michael A. Ferragamo, MD, FACS, clinical assistant professor of urology at the State University of New York at Stony Brook.

Take Note of Urogynecology Edits

If you code for a urogynecologist, you'll face new bundles as well. Column 1 codes 57282 (Colpopexy, vaginal; extra-peritoneal approach [sacrospinous, iliococcygeus]) and 57283 (... intra-peritoneal approach] uterosacral, levator myorrhaphy]) bundle column 2 code 56810 (Perineoplasty, repair of perineum, nonobstetrical [separate procedure]).

"Thus when performing either an extra-peritoneal (57282) or an intra-peritoneal (57283) colpopexy, the repair of the perineum via a perineoplasty would be included in either code (57282 or 57283) and not a billable service," Ferragamo explains. These edits have a modifier indicator of "0."

Reasoning: "The bundle with 56810 is there because this code is a CPT® 'separate procedure' which is integral to lots of vaginal procedures for prolapse, and many times when there is vaginal vault prolapse the physician will also repair the perineum," says **Melanie Witt, RN, CPC, COBGC, MA**, an ob-gyn coding expert based in Guadalupita, N.M. "Once provider billing patterns begin to show an increase in billing two procedures codes together where a CPT® guidelines applies, they will then add the bundle which is why it not all 'separate procedure' codes have been added to CCI up to this point."

Additionally: You'll also want to take note of a few other urogynecology edits in CCI 20.2.

First, you'll find 38505 (Biopsy or excision of lymph node[s]; by needle, superficial [e.g., cervical, inguinal, axillary]) now bundled into vulvectomy codes 56632 (Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy) and 56637 (Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy). These edit pairs have a modifier indicator of "1."

You can no longer report 56810 (Perineoplasty, repair of perineum, nonobstetrical [separate procedure]) with 57010 (Colpotomy; with drainage of pelvic abscess). This edit pair has a modifier indicator of "0," meaning that you can never unbundle the codes.

You also shouldn't report 57000 (Colpotomy; with exploration) when reporting 57135 (Excision of vaginal cyst or tumor), per CCI. "This bundling indicates another long held coding view that an exploration of the surgical field is included as part of the performed surgical procedure," Ferragamo explains. This bundling has a modifier indicator of "1."

Don't Report New and Established E/Ms Together

Some of the latest edits focus on E/M codes you likely use in your practice every day, but the bundles really won't change very much the way you code for these visits. Per CCI 20.2 column 1 codes, new patient office visits (99201-99205, Office or other outpatient visit for the evaluation and management of a new patient ...) bundle column 2 codes, established office visits (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient ...).

"This actually reinforces a long held and known coding policy that a physician and/or an NPP may not bill for more than one office visit per day unless each visit represents a separate and different medical problem," Ferragamo says.

"These codes were disallowed by definition, but there are exceptions in the clinic setting," agrees **Barbara J. Cobuzzi, MBA, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "If the E/Ms are bundled in the physician fee schedule, it applies, but not with the facility spin. To me it is a 'duh, of course, we know that a single physician can't bill more than one E/M in a day."

Similarly, established patient visit codes 99212-99215 bundle lower-level established patient visits. For example, 99212 bundles 99211, 99213 bundles 99211 and 99212, and so on. "Therefore, one should not be able to bill for a patient seen twice in one day billing both CPT® codes 99212 and 99213," Ferragamo says.

All of the above E/M edit pairs have a modifier indicator of "1."

Add G0463 Bundles to Your Edit List

CCI 20.2 bundles new HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) with every CPT® codes in the urinary system (50010-55920 with the exception of unlisted urinary system codes) as well as CPT® codes for urogynecology and the integumentary system (skin).

"Code G0463 replaced CPT® codes 99201-99205 (new patient visit) and 99211-99215 (established patient visit) for facility billing of outpatient clinic visits," Witt says. "This new bundle will not affect physician payment, but will impact a facility that is trying to bill an outpatient clinic visit as well as the service it is bundled into. This bundle just levels the playing field for bundles that apply to physicians and those that apply to outpatient facilities."

"Last spring CCI added a bundle of all minor procedures to established E/M codes," Cobuzzi says. "It is not enough for them that the definition of the global period includes a mini E/M, they have to make it even harder and more iron clad that the E/M and the minor procedure are not to be billed together by bundling them, adding an additional level of hurt on top of the global period definition."

Don't Assume Modifier 59 Applies

These bundles all have a modifier indicator of "1." That means you can bypass the edit with an appropriate modifier if you can meet the criteria for doing so.

In writing: Per the CCI manual: "A CPT® code with the 'separate procedure' designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach."

Watch out: Often modifier 59 (Distinct procedural service) is the appropriate modifier for unbundling codes that would be

deemed separately billable per CCI. However, that is not always the case.

For example, G0463 would not take a modifier 59 because it represents an E/M service, and the only modifiers that would apply would be modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period), 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service), or 57 (Decision for surgery).

Tip: "And, by the way, the modifier 25 is not reported for the decision to do a minor procedure; CMS considers the decision to do a minor procedure, part of the surgical code," Witt warns. "That clinic visit would have to represent a separate and significant E/M service."