Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: General Surgery: Some CCI Edits Can Cause Trouble

Be aware of modifier 59 as an option to help navigate the changes.

When your general surgeon reports multiple CPT® codes for a patient's case, you always need to steer clear of any limitations imposed by the Correct Coding Initiative (CCI) edits.

As of April 1, you've had even more edit pairs to avoid, since CCI 22.1 went into effect. Read on to get expert advice about which code pairs you need to watch out for.

Look for Skin Procedure Pairs

You now have dozens of excision and repair codes bundled into CPT® code +14302 (Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof [List separately in addition to code for primary procedure]).

According to CCI, +14302 is now a column 1 code for all of the codes from the range 11400-11471 (benign lesion excision), 11600-11646 (malignant lesion excision), 12001-12021 (simple repair), 12031-12057 (intermediate repair), and 13100-13160 (complex repair).

Impact: Because all of those column 2 codes were already bundled into CPT® code 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and +14302 is an add-on code that you can report only in addition to 14301, you were essentially restricted from reporting these services together even before April 1.

"But the tricky thing is that we never used to have to worry about putting modifiers on add-on codes because CCI didn't bundle them. Now, if you have a bundled add-on code that should be appropriately unbundled, you will need to be sure to include modifier 59 on the add-on code as well as the base code. If you don't, you'll get a denial for the add-on code even if the base code is paid. This is a significant change in the way we have done our billing," says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC**, internal audit manager with PeaceHealth in Vancouver, Wash.

RCM edits: CCI 22.1 adds some other new skin bundles that you should know about if your surgeon uses reflectance confocal microscopy (RCM). CPT® 2016 added the following six codes for RCM procedures, and CCI 22.1 now bundles these as Column 2 codes with 25 other integumentary codes for skin biopsy (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) and benign skin lesion excision (11400-11471):

- 96931 Reflectance confocal microscopy [RCM] for cellular and subcellular imaging of skin; image acquisition and interpretation and report, first lesion
- 96932 ... image acquisition only, first lesion
- 96933 ... interpretation and report only, first lesion
- 96934 ... image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)
- 96935 ... image acquisition only, each additional lesion (List separately in addition to code for primary procedure)
- 96936 ...interpretation and report only, each additional lesion (List separately in addition to code for primary procedure).

Background: Reflectance confocal microscopy involves focusing near-infrared light on the skin to detect any abnormal lesions or scar formation. The light source connects to a computer that displays the image of the tissue under

examination.

CCI lists these with a modifier indicator of "1," meaning that you can override the edit pair if the surgeon performs the four procedures at different body sites or operative sessions.

Example: The patient presents with three suspicious lesions: one on the upper right arm, one on the left upper back, and one on the nose. The surgeon biopsies the lesion on the left upper back and monitors the remaining two lesions for changes by acquiring and interpreting images using RCM. You should code the biopsy on the back as 11100, the RCM on the arm as 96931-59, and the RCM on the nose as 96934-59, says **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas.

Focus on IV Infusion Procedures

- Under CCI 22.1, you'll find virtually every surgical procedure your physicians are likely to perform from integumentary codes (10000s) to the digestive system codes (40000s) bundled with the following Column 2 codes:
- +96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
- +96366 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
- +96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
- +96368 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure).

"These are all 'add-on' codes and cannot be billed alone," points out **Michael A. Ferragamo, MD, FACS**, clinical assistant professor at the State University of New York at Stony Brook. "They must be billed with a primary code and, if the codes are bundled, billed with a modifier to break the bundle and be paid."

Good news: Each edit pair carries a modifier indicator of "1," meaning that you might be able to report both codes in an edit pair if you have sufficient documentation to support separate coding. If so, you should append a modifier (such as 59, Distinct procedural service) to the Column 2 code.