Eli's Rehab Report

Don't Get Too Cozy With New Orthotic, Chemodenervation Codes -- NCCI 12.0 Attacks!

Be cautious when reporting anesthetic agents along with 65650 and 64653

If you've just now got a handle on physical medicine and rehab's new orthotic and chemodenervation codes, you may find your work is only half done -- thanks to the extensive National Correct Coding Initiative (NCCI) edits that kicked off the new year. But it's not all bad news: you've got some welcome electromyography (EMG) deletions to look forward to as well.

Rejoice in the EMG Deletions

First of all, you have cause to cheer. NCCI 12.0 sweeps through and deletes a slew of edits for nerve injections and electromyography (EMG) codes. "This is great news for physical medicine and rehab coders," says **Marvel Hammer, RN, CPC, CCS-P, CHCO,** owner of MJH Consulting in Denver.

Why: The deleted edits carried a modifier indicator status of "0," which meant that you could not bypass the edits no matter whether your physiatrist performed the services on distinctly different anatomic regions or during separate sessions. Payers who follow the NCCI edits would not process the electrodiagnostic study services.

Additionally, cranial nerve EMG services do not fit the "definition" of a component procedure to the nerve injection services, Hammer notes. The cranial nerves originate from the brain or brainstem and not from any of the spinal regions (cervical, thoracic, lumbar, or sacral). "Anatomically, these by definition are distinct and different anatomic locations. The edits just didn't fit with these specific electrodiagnostic studies," Hammer says.

Important: No longer will you have to worry about scheduling cranial nerve EMG services 95867 (Needle electromyography; cranial nerve supplied muscle[s], unilateral) and 95868 (... cranial nerve supplied muscles, bilateral) on different days from the following injection codes:

• 64470 -- Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level

• 64475 -- ... lumbar or sacral, single level

• 64479 -- Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level

• 64483 -- ... lumbar or sacral, single level.

Now your physiatrist can perform these services and receive reimbursement for both procedures. "I'm pleased with [these kinds of] deletions," says **Chris P. Galeziewski, CPC**, senior coding compliance specialist at the Kelsey-Seybold Clinic in Houston, Texas.

Heads up: You'll also find that you can tread less cautiously when reporting 64550 (Application of surface [transcutaneous] neurostimulator). This transcutaneous electrical nerve stimulation (TENS) code represents when the physiatrist places electrode pads on the patient's skin. You can now report this code separately from the following services:

• auditory evoked potentials (92585),

• sleep EEG (95822),
• needle electromyography procedures (95860-95861, 95867-95868, 95870),
• nerve conduction tests (95900, 95904),
• intraoperative neurophysiology testing (95920), and
• evoked potentials and reflex tests (95925-95937).

In other words, Medicare will reimburse you when you report 64550 in addition to one of these listed codes on the same date of service.

Watch Out for Orthotic Code Edits

If you're wondering if you can report the new orthotic checkout code (97762, Checkout for orthotic/prosthetic use, established patient, each 15 minutes) along with 97755 (Assistive technology assessment [eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility], direct one-on-one contact by provider, with written report, each 15 minutes), then the answer is no -- not if you're billing Medicare or any other payer that follows NCCI edits.

NCCI version 12.0 bundles 97762 into 97755 as mutually exclusive codes. Because the bundle carries an indicator of "0," no modifier can separate this bundle, and Medicare will always deny 97762 when you bill it with 97755.

Rationale: This edit makes sense, based on the description of 97762 in CPT Changes 2006: An Insider's View, Galeziewski points out. According to the publication, "97762 is intended to report the assessment for determination of an established patient's response to the orthotic including redness and/or pressure areas and making any necessary adjustments." Therefore, because both codes describe assessments, it appears that you would be double-billing if you reported them together.

Red flag: The new edition of NCCI also bundles 97762 into 97760 (Orthotic[s] management and training [including assessment and fitting when not otherwise reported], upper extremity[s], lower extremity[s] and/or trunk, each 15 minutes) and 97761 (Prosthetic training, upper and/or lower extremity[s], each 15 minutes). But you can use a modifier (such as 59, Distinct procedural service) to separate these bundles if you perform the services during separate sessions or on separate sites.

Note: You should also remember that NCCI pairs most pain management codes (62310-62319, 64400-64530, 97002-97124, 97140, 97755) into the new orthotic codes 97760 and 97761. You can bypass these edits with proper documentation and a modifier, if necessary.

Expect These Chemodenervation Edits

NCCI 12.0 affected more than just the new orthotic codes. New chemodenervation codes +95873 (Electrical stimulation for guidance in conjunction with chemodenervation [List separately in addition to code for primary procedure]) and +95874 (Needle electromyography for guidance in conjunction with chemodenervation [List separately in addition to code for primary procedure]) have new edits as well.

NCCI 12.0 prevents you from using these codes with needle electromyography codes 95860-95874. Remember: Because these edits carry a modifier indicator "1," you can possibly report these codes separately along with supporting documentation and a modifier (such as modifier 59).

These updates shouldn't catch you by surprise. Chemodenervation codes are easy targets for **NCCI Edits** , Galeziewski says. "They're to be expected," Hammer adds. They support CPT's parenthetical notes following 95873 and 95874, which state, "Do not report 95873, 95874 in conjunction with 95860-95870." Providers shouldn't "double-dip" by using the needle guidance codes in addition to the needle EMG study codes for the same services, Hammer says.

In Addition: When you're preparing to report a chemodenervation or destruction by neurolytic agent code (64612-64622, 64626, 64630-64681), then you should also be prepared for a slew of other NCCI 12.0 updates.

According to this latest round of NCCI, you cannot report 64612-64614 and 95870 (Needle electromyography; limited study of muscles in one extremity or non-limb [axial] muscles [unilateral or bilateral], other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters) together and expect reimbursement for both. The same goes for 64640 (Destruction by neurolytic agent; other peripheral nerve or branch) and 95870.

Rationale: These edits are according to "HCPCS/CPT coding manual instruction/guidelines," says NCCI -- but you can still bypass this edit so long as you have documentation showing your physiatrist performed these two procedures separate and distinct from one another.

For example, if your physiatrist performed a diagnostic limited EMG study on muscles in the leg for muscle weakness (96870) and a radiofrequency destruction of the greater occipital nerve for chronic occipital neuralgia, you can report both procedures using a modifier 59.

Other notable updates include 64650 (Chemodenervation of eccrine glands; both axillae) and 64653 (...other area[s]; [eg, scalp, face, neck], per day) and two anesthetic agent codes. Because NCCI includes the anesthesia in surgical procedures, you should not report 64650 along with either anesthetic agent injection codes 64417 (Injection, anesthetic agent; axillary nerve) or 64450 (...other peripheral nerve or branch). The same goes for 64653 and anesthetic agent codes 64400-64405, 64630, 64447, 64450. Again, you can bypass these edits so long as you have documentation supporting the use of a modifier -- but that should be a last resort, not the rule.

Finally, all of these destruction codes now carry edits that involve the new injection/infusion codes (90760-90775). But they aren't the only such edits.

Read Up on the Rest of the Updates

NCCI 12.0 contains many edits pertaining to the new 2006 injection/infusion codes (90760-90775). Edits that you would have seen applied to Medicare's old G code equivalents are now shifted to the new codes. "NCCI is merely updating edits for the new injection/infusion codes," Hammer says.

For example, unless you have documentation demonstrating how the injection was separate and distinct and supports the use of a modifier, you won't report 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) in addition to 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]).

FYI: Most E/M codes are bundled as column 2 components into the new injection/infusion codes but similarly, you can bypass the edits with a modifier if your documentation supports its use.