Eli's Rehab Report

Understanding Medicare's CCI Is Powerful Compliance Tool

Unbundling, breaking down a single procedure into its component parts and billing for additional services, is a major compliance problem. But many physicians dont understand this concept, which can lead to claim denials. By reviewing the basic ideas behind bundling, such as component and comprehensive codes, physiatrists can avoid such problems.

By far the largest source of bundling combinations, or edits, is Medicares national Correct Coding Initiative (CCI), which has developed coding policies and more than 120,000 edits for reimbursement compliance to better control improper coding.

Although the CCI Edits has been in place since Jan. 1, 1996, many physiatrists still do not understand its impact on how they bill procedures. This has serious compliance consequences because Medicare auditors may construe billing for procedures bundled into others as fraud.

Mutually Exclusive Codes

The CCI is particularly important to PM&R practices because the billing for many of the procedures they perform is guided by its policies. Approximately 11,000, or just less than 10 percent, of the CCIs 120,000 edits are categorized as mutually exclusive. These code pairs describe procedures that would not be performed reasonably for the same patient by the same physician on the same day.

For example, if the physician is billing for 24-hour EEG monitoring for localization of seizure focus using a portable 16-channel EEG recording (95953), the practice cannot bill 95956 (monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, EEG recording and interpretation, each 24 hours) also, to transmit the results telemetrically. This is because the 95956 is not performed separately. Mutually exclusive codes are not considered bundled, but they do represent codes that should not be reported together.

Component and Comprehensive Codes

About 90 percent of CCI edits may be categorized roughly as bundles comprehensive codes that include component codes. Physicians may not bill the component codes if they also charge for the comprehensive procedure.

For example, the service for code 20550 (injection, tendon sheath, ligament, trigger points or ganglion cyst) is included in the service for code 20610 (arthrocentesis, aspiration and/or injection; major joint or bursa). Section 4630 of the Medicare Carriers Manual states, Accordingly, only the most extensive service, 20610 (comprehensive code), performed is reported.

CCI further subdivides the comprehensive/component code category according to various principles used to determine the edit. These subcategories include:

1. CPT Definition. Some CPT codes are part of a series in which the first code becomes a component for the codes that follow it, because they refer back to the common portion of the procedure listed in the first code. This relationship is indicated in the CPT manual by the convention of indentation and semicolon. It states that the indented code refers back to a common portion of the procedure (that part before the semicolon) listed in a preceding entry.

For example, removal of a foreign body in muscle or tendon sheath; simple (20520) is followed by the indented code 20525 (removal of foreign body in muscle or tendon sheath; deep or complicated). If the physician performed both procedures, then only code 20525 would be reported because the 20520 procedure is a component of it.

2. CPT Manual Instructions/Guidelines. CPT also gives bundling instructions at the beginning of some sections in the manual, and after certain CPT codes. For example, following code 97537 (community/work reintegration training, each 15 minutes), it states, for wheelchair management/propulsion training, use 97542. This statement simply instructs the biller to use the more specific code 97542 (wheelchair management/propulsion training, each 15 minutes) rather than the more generic 97537.

3. Sequential Procedures. Sometimes physiatrists begin with a more general procedure and then continue on to a more specific procedure in the same session. In this case, the procedures are considered sequential, and the more specific code should be reported.

For example, if the physician attempts a vertebral biopsy using a trocar or needle (20225) and follows it by an open biopsy (20250) at the same session, only the more comprehensive biopsy procedure (20250) should be reported.

4. With vs. Without Procedures. The only difference between 95900 (nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study) and 95903 (motor, with F-wave study) is the fact that 95903 includes an F-wave study. Therefore, billing for both codes at the same time for the same nerve would be inappropriate. The service for 95900 is considered a component code of 95903.

5. Anesthesia Included in Surgical Procedures. For example, a physiatrist may perform a digital nerve block (64450) before performing a joint or ganglion aspiration (20600). Because the block is being performed for the primary procedure (which in this case is the joint aspiration), 64450 is not reportable separately, but is bundled into 20600.

Judiciously Use Modifiers That Override Bundles

Modifiers to indicate that distinct or independent procedures were performed may override most CCI edits. If special circumstances result in two different services being provided, billing with two codes that normally would be bundled is appropriate. The special circumstances usually entail procedures carried out on separate body sites, or during different times of the same day. Payers say that they would expect these circumstances to be rare.

Modifier -59 (distinct procedural service) was created as a response to the CCI edits and can override most, but not all, bundling combinations. The CCI uses indicators to show which codes appropriately may use modifier -59 if documentation exists to support the claim that the procedures were distinct and independent.

Medicare also has developed its own HCPCS modifiers to indicate that procedures were performed on different sites on the body. These include -LT left side (used to identify procedures performed on the left side of the body), -RT right side, and -TA through -T9 (toes).

Whether or not codes can be reported together using modifiers under appropriate circumstances is indicated by the presence of a superscript number next to the codes in the CCI edit list. If the codes can be modified, they will have an indicator (1) beside them in the CCI. If they cant, indicator (0) is shown. Most of the mutually exclusive codes cannot be modified.

Physiatrists may bill many of the edits in the comprehensive/component category and its subcategories using modifier -59 when appropriate. For example, if you are billing the nerve conduction studies noted above in example four (95900 and 95903) for different nerves, practices can bill both codes by appending modifier -59 to 95900. These practices should keep in mind, however, that CPT 2000 states, only if no more descriptive modifier is available and the use of modifier -59 best explains the circumstances, should modifier -59 be used. Therefore, this modifier should be used carefully and discriminately after ensuring that the appropriate documentation exists to back up the claim.

Although the Correct Coding Initiative is important, it is not the only group of coding edits that Medicare uses. The Health Care Financing Administration (HCFA) instituted many edits before the CCI was established in 1996 and still enforces these. In addition, HCFA purchased a series of edits from HBO&C, which the agency refers to as commercial or proprietary edits and the rest of the coding world knows as black box edits because they are not published anywhere due to their proprietary nature.

Finally, physiatrists should remember that commercial carriers are not bound by and do not follow the CCI necessarily, though they may use it selectively. Individual payers should be contacted for their specific edit rules.

Note: For concerns about CCI edits, contact the provider-relations staff of your local Medicare carrier. The National Technical Information Service (NTIS) publishes the CCI edits, along with several other commercial resellers who purchase the raw data from NTIS. The edits can be purchased from any of the vendors.

Editors note: This article was prepared with the help of **Garnet Dunston, CPC, MPC**, president of Dunston Enterprises, a coding and consulting firm in Phoenix, and **Susan Callaway-Stradley, CPC, CCS-P,** an independent coding specialist and educator in North Augusta, S.C.