QUARTERLY UPDATES
NATIONAL CORRECT CODING INITIATIVE (NCC/CCI)

Refer to **User Guide: National Correct Coding Initiative (NCCI)**

According to The Centers for Medicare & Medicaid Services (CMS), the National Correct Coding Initiative (NCC/CCI) was developed to encourage correct coding methodologies and to regulate improper coding that leads to inappropriate payment for Part B claims. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS *(through an outsourced vendor - Correct Coding Solutions, LLC.)* develops these coding policies based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Effective with the October 1, 2011 Procedure-to-Procedure (PTP) and Medically Unlikely Edit (MUE) quarterly version updates, CMS began posting the changes to each of its NCC/CCI edit files on a **quarterly basis**, however a summary (scorecard) of changes is not provided by CMS (*Correct Coding Solutions, LLC)*.

MEDTRON has relied on *Decision Health, Part B News* for summaries and scorecards outlining the quarterly CMS NCC/CCI changes. Providers may have noticed that MEDTRON did not publish the NCC/CCI quarterly news blasts associated with NCC/CCI updates for July 2015, Version 21.2 or October 2015, Version 21.3. This is a result of Decision Health taking a break from publishing the scorecards which outline the changes. MEDTRON has reached out to CMS to suggest that CMS or Correct Coding Solutions, LLC provide each quarters summary as these bundling edits have a huge impact on a providers revenue and reached out to Decision Health to resume providing their quarterly scorecard summaries of the NCC/CCI edits.

Since their brief hiatus, Decision Health has, resumed publishing the scorecards, i.e., they have published a scorecard for the January 2016, version 22.0 quarterly updates. See below information MEDTRON has obtained related to the missing quarters as well as the latest quarterly update.

Version 22.0, Changes Effective January 1, 2016

In CCI version 22.0 edits CMS has added effective dates and deletion dates, where appropriate, for each of the Medicare **Add-on Code Edits** to aid in determining the active period of an add-on code edit for Medicare Services.

An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service, *with one exception (see CR7501 for details)*. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code is never eligible for payment if it is the only procedure reported by a practitioner.

Add-on codes may be identified in three ways:

- The affected code is listed in CR7501 or subsequent ones as a Type I, Type II, or Type III add-on code.
- On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
- In the *CPT Manual* an add-on code is designated by the symbol "**+**". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three groups to distinguish the payment policy for each group.

- Type I - A Type I add-on code has a limited number of identifiable primary (lead) procedure codes. *CR7501* lists the Type I add-on codes with their acceptable primary (lead) procedure codes. A Type I add-on code is eligible for payment if one of the listed primary (lead) procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary (lead) procedure code is also paid.
- Type II - A Type II add-on code does not have a specific list of primary procedure codes. CR7501 lists the Type II add-on codes without any primary (lead) procedure codes. Claims processing contractors are encouraged to develop

their own lists of primary (lead) procedure codes for this type of add-on codes. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary (lead) procedure code, as determined by the claims processing contractor, is also eligible for payment to the same practitioner for the same patient on the same date of service.

- Type III - A Type III add-on code has some, but not all, specific primary (lead) procedure codes identified in the *CPT Manual*. CR7501 lists the Type III add-on codes with the primary (lead) procedure codes that are specifically identifiable. However, claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary (lead) procedure codes for add-on codes in this Type. Claims processing contractors are encouraged to develop their own lists of additional primary (lead) procedure codes for this group of add-on codes. Like the Type I add-on codes, a Type III add-on code is eligible for payment if an acceptable primary (lead) procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

CMS will update the list of add-on codes with their primary procedure codes on an annual basis on or by January 1 every year based on changes to the *CPT Manual or HCPCS Level II Manual*. Quarterly updates will be posted as necessary on April 1, July 1, and October 1 each year. If no changes occur in the add-on code edits for one quarter, no quarterly update will be posted.

Source: Part B News, January 12, 2016 Vol. 30, Issue 2:
CCI: Don't bill E/M and CPAP together; use ACP in the hospital

More on Version 22.0, Changes Effective January 1, 2016:
Specify the primary and secondary locations for specific procedures involving bundled codes, such as lesion removal and nail debridement, and heed other code pairs that are under CMS' spotlight to avoid losing out on revenue in 2016.

Providers can wield modifier 59 (Distinct procedural service) in some cases to show your payers you're performing a separately billable procedure, but pay attention to new rules and clarifications when you perform multiple services, according to the latest edits to the National Correct Coding Initiative (CCI) policy manual.

Effective Jan. 1, the edits clarify billing protocols for a number of primary care services.

Report separate digits separately. Providers can bill CPT code **11055** (Paring or cutting of benign hyperkeratotic lesion) with code **11720** (Debridement of nail[s] by any method; 1 to 5) as long as the two procedures are performed on different fingers. The two codes are bundled, but providers can use modifier 59 as evidence of the distinct procedure.

> "This means that if you are paring a callus on the right great toe near the nail area (11055), you can report 11720 with a modifier 59 if you are debriding the right second and third toes," explains Margie Vaught, CPC, a consultant based in Chehalis, Wash. "But if you are paring a corn/callus of the right great toe near the nail area and also debriding that great toe nail, you can only report the column-one code [11055]."

Follow size guidelines for lesion removal and repair. Be careful when reporting an intermediate or complex repair procedure following a lesion removal, advises the CCI policy manual. Specifically, providers should avoid reporting a repair code with lesion-excision codes **11400, 11420 and 11440** when the lesion measures 0.5 cm or less. This batch of codes "includes simple, intermediate or complex repairs, which should not be reported separately," states the policy manual. However, the new guidance allows providers to report a repair code in addition to the lesion-removal code when the lesion is or lesions are larger than 0.5 cm. "If more than one lesion is removed and one of those lesions is larger than 0.5 cm, an intermediate or complex repair may be reported, if performed, for a lesion larger than 0.5 cm," states the policy manual.

Don't let a small lesion dissuade providers from reporting a repair code when other, larger lesions are also present. "Removal of one lesion smaller than 0.5 cm does not preclude also reporting an intermediate or complex repair for a larger lesion," states the manual.

Evaluate E/M, other 90000 series codes
Use modifier 25 with hyperbaric oxygen therapy, but be careful. CMS gave the green light to providers to bill hyperbaric oxygen therapy (**99183**) with E/M services using modifier 25, provided they can show medical necessity, in the CCI 21.3 coding update (PBN 10/5/15). Now CMS is fleshing out this rule in the policy manual, where it states that 99183 E/M services include "updating history and physical, examining the patient, reviewing laboratory results and vital signs with special attention to pulmonary function, blood pressure and blood sugar levels, clearing patient for procedure, monitoring and/or assisting with patient positioning, evaluating and treating the patient for barotrauma and other complications,

prescribing appropriate medications, etc." In short, if providers don't go beyond the services listed above, don't bill an E/M code with 99183 and expect to get paid.

Don't unbundle ventilation management and critical care codes. The CCI policy manual states that practitioner ventilation management codes **(94002-94005, 94660 and 94662)** and critical care codes **(99291, 99292, 99466-99486)** include the following services: respiratory flow volume loop (94375), breathing response to carbon dioxide (94400) and breathing response to hypoxia **(94450)** — so don't bill the latter codes in addition to the former ones.

Be careful with E/M code bundles because this type of guidance means that "CMS is seeing a higher volume of providers trying to unbundle services," explains Vaught. And that means they might be paying closer attention to claims involving these codes.

Mind musculoskeletal modifications

Providers will find additional coding guidance related to dislocations in the 2016 policy manual, after CMS clarified the **"single cast rule"** in the 2015 policy manual, which restricts practices to billing one code per cast regardless of the number of fractures within the cast (PBN 2/2/15).

The new rules have "added dislocation treatment, which now broadens the noncoding for closed treatment or a fracture or dislocation," explains Vaught. "If multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported," states the policy manual.

Now providers will want to treat dislocations the same as fractures. Example: "If a cast is applied without manipulation to treat fractures of multiple metatarsals of the same foot, only one unit of service of CPT code **28470** may be reported for that treatment," states the policy manual.

CMS also clarified billing protocol for code **20650** (Insertion of wire or pin with application of skeletal traction, including removal [separate procedure]), which "should not be reported for insertion of wires or pins without application of skeletal traction," according to the CCI policy manual.

With this, CMS is "further reminding that 20650 can't be used for positioning of the patient during surgery," notes Vaught.

Source: Part B News, December 14, 2015 Vol. 29, Issue 47:
CCI: Don't unbundle codes without cause, watch anatomic location

Version 21.3, Changes Effective October 1, 2015 (No Scorecard)

Hyperbaric Oxygen Therapy

Elevate patients' oxygen levels through hyperbaric oxygen therapy (**99183**) and breathe easy knowing you'll get paid for an E/M service on the same date — provided medical necessity can be proven. Medicare confirmed it will pay hyperbaric oxygen therapy with a same-day E/M service by giving the code pair a modifier "1," according to version 21.3 of the National Correct Coding Initiative (CCI) edits that go into effect Oct. 1.

Be sure to attach modifier 25 (Significant, separately identifiable E/M service by the same physician on the same date of service) to the E/M service to show that the patient encounter went above and beyond the oxygen therapy code, notes Ann Silvia, CPC, regional director revenue cycle, Reid Physician Associates, Richmond, Ind. For example, provider may see a patient with a diabetic wound and decide the current treatment plan is not effective, "so a new evaluation and management service and plan are indicated," notes Silvia. When the new plan calls for hyperbaric oxygen therapy, bill 99183 in addition to the appropriate E/M code.

Medicare claims data from 2014, the latest year available, show that providers see a 12% denial rate for 99183, which translates to $9.6 million in lost revenue. Remember that Medicare considers hyperbaric oxygen therapy an "adjunctive therapy" for wound care, according to CMS' national coverage determination (NCD) on the service.

The NCD stipulates that Medicare cover hyperbaric oxygen therapy "only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy." Providers must also evaluate wounds at least once every 30 days. Make sure documentation shows wound improvement, such as a reduction in edema or improved wound hypoxia, or else Medicare won't pay. "Continued treatment with HBO [hyperbaric oxygen] therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment," states the NCD.

HPV testing codes can be billed together

CCI version 21.3 edits also make a subtle change to human papillomavirus (HPV) testing, which may be increasingly part of a providers workflow now that it's a covered preventive service (PBN 8/17/15). The CCI edits paired two types of HPV testing with a "1" modifier, which means they'll be paid when billed with the same date of service provided the documentation shows medical necessity. The HPV codes in question are:

- **87624** (Infectious agent detection by nucleic acid [DNA or RNA]; Human Papillomavirus [HPV], high-risk types [e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68])
- **87625** (Infectious agent detection by nucleic acid [DNA or RNA]; Human Papillomavirus [HPV], types 16 and 18 only, includes type 45, if performed)

Providers might use both tests on the same date if he/she conducted a broad-panel test first and then follow with genotyping if the broad-panel test comes back positive, says Diane Harper, M.D., MPH, MS, chair of the department of family and geriatric medicine, University of Louisville Physicians. For instance, if the provider uses Cervista HPV tests, he/she will find that the broad-panel test is a separate item from the genotyping test, offers Harper.

Be mindful of other notable edits, code pairs:

- Flu vaccine codes **Q2034-Q2039** are paired with a "1" modifier with flu vaccine codes 90664-90668. The new code pairs expand on CCI version 21.2 edits, which paired Q2034-Q2039 with other flu vaccine codes in the range of **90653-90688** but had skipped over 90664-90668. The expanded code pairs appear to be a way for Medicare to capture Q-code billing, notes Margie Scalley Vaught, CPC, a Chehalis, Wash.-based consultant.
- Most of the remaining new CCI 21.3 code pairs bundle blood draw codes 36591 (Collection of blood specimen from a completely implantable venous access device) and **36592** (Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) as components of most procedure codes. Those edits will not allow providers to append a modifier to override them.
- Expect new per-day limits on chronic pain treatment **J7336** (Capsaicin 8% patch, per square centimeter), which Medicare will limit to 1,180 units per patient per day, according to medically unlikely edits (MUEs) that go into effect Oct. 1. A capsaicin patch lasts "only a few hours" and additional patches may need to be prescribed, notes Maxine Lewis, president, Medical Coding and Reimbursement, Cincinnati. Note that J7336 reflects a unit as a centimeter, so don't be fooled by the seemingly large limit of 1,180.
- Providers are limited to billing coagulation test **85397** (Coagulation and fibrinolysis, functional activity, not otherwise specified [e.g., ADAMTS-13], each analyte) a maximum of three times per day. Be careful about usage because "coagulation activity is probably used multiple times in a day to monitor the coagulation process if the patient is having problems," notes Lewis.

Source: Part B News, October 5, 2015, Vol. 29, Issue 38:
CMS gives green light to bill hyperbaric oxygen therapy with E/M, limits others

NOTE: Part B News did not release a 21.3 scorecard.

Version 21.2, Changes Effective July 1, 2015 (No Scorecard)

Behavioral Counseling

In CCI version 21.2 edits effective July 1, 2015, Medicare bundled G0473 and more than 100 codes with a modifier indicator of "1," which allows providers to report the two services on the same day provided medical necessity supports it.

The edits stipulate that providers can bill code **G0473** (Face to face behavioral counseling for obesity, group [2-10], 30 minutes) with E/M service codes **99201-99215** on the same date of service only if the documentation supports the two services and clearly shows medical necessity.

> **Example:** The Provider sees a patient to check on hypertension levels, and the patient subsequently takes part in a group counseling session for obesity. The Provider must document the elements of the E/M visit that occurred prior to the counseling session in addition to noting his/her time for the 30 minutes spent on G0473.

The latest edits involving G0473 are a good reminder "not to double dip," explains Betsy Nicoletti, president, Medical Practice Consulting in Northampton, Mass. Billing an E/M service with G0473 when the entire office visit involves the behavioral health screening and nothing else means that the provider is "using the same 30 minutes and pretending that he/she is doing two services instead of one," says Nicoletti.

Don't bill an E/M erroneously. Instead, bill the G0473 by itself if the counseling was all that was provided. Otherwise, clearly indicate which other service the provider delivered if billing an E/M along with the counseling code — and attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same

day of the procedure or other service) to the E/M code. “The provider will have to support that he/she did two separate services,” advises Margie Scalley Vaught, a Chehalis, Wash.-based consultant.

No claims data is available for G0473 because the code launched Jan. 1. However, G0473 is an update to code **G0447** (Face-to-face behavioral counseling for obesity, 15 minutes), which plagued providers with a 31% denial rate in 2013, according to 2013 Medicare claims data, the latest available. In 2013, providers billed G0447 nearly 160,000 times and received $2.8 million in reimbursement for the screening code against more than $2.5 million in denied claims.

Tip: Use the correct diagnosis code when billing G0473 or the claim will get denied, according to an April 8 MLN Matters notice: “The MACs will recognize HCPCS code G0473 but only when billed with one of the ICD-10 codes for body mass index (BMI) 30.0 and over Z68.30-Z68.39 and Z68.41-Z68.45.”

The CCI edits also bundle G0473 with hospital and emergency codes **99217-99288**, critical care and nursing facility codes **99291-99354** and advance care planning code **99497**.

Be careful about billing other psychiatric services on the same date of service as group behavioral obesity counseling.

The latest CCI edits also bundle G0473 with the following psych codes:

- **90791** (Psychiatric diagnostic evaluation)
- **90792** (Psychiatric diagnostic evaluation with medical services)
- **90832** (Psychotherapy, 30 minutes with patient and/or family member) to **90869** (Therapeutic repetitive transcranial magnetic stimulation [TMS] treatment; subsequent motor threshold re-determination with delivery and management)
- **96150** (Health and behavior assessment [e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires], each 15 minutes face-to-face with the patient; initial assessment) to **96154** (Health and behavior intervention, each 15 minutes, face-to-face; family [with the patient present]).

Colorectal Cancer Screening

The CCI version 21.2 edits make it clear that providers can’t bill stool analysis and other testing codes with colorectal cancer screening code **G0464**. The CCI edits attach a “0” modifier to the following code-pair bundles, which means Medicare won’t pay for the two services when they’re provided to a patient on the same date of service:

- G0464 and **G0328** (Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous)
- G0464 and **81275** (Gene analysis [v-Ki-ras2 Kirsten rat sarcoma viral oncogene] variants in codons 12 and 13)
- G0464 and **82270** (Stool analysis for blood to screen for colon tumors)
- G0464 and **82272** (Blood, occult, by peroxidase activity [e.g., guaiac], qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening)
- G0464 and **82274** (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations)

Source: Part B News, June 15, 2015 Vol. 29, Issue 23:
CCI update: Don’t overbill for obesity behavioral counseling, E/M visits

NOTE: Part B News did not release a 21.2 scorecard.

See the NCCI Policy Manual for Medicare Services Effective 01/01/2016:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/2016-NCCI-Policy-Manual.zip

See prior News Blasts for previous NCCI Changes *(available via www.medtronsoftware.com).*

Contact Software Support for assistance or any questions via:
From **MED**PM or **MED**EHR Sign On screens, double click on ‘support@medtronsoftware.com’ to compose an email to the Software Support Dept.
-OR-
Phone: (985) 234-0599 (local)
(800) 978-0599 (toll free)
-OR-
Fax: (985) 234-0609

Scorecards:

NCCI Changes Version 22.0 effective January 1st, 2016

CCI Version 22.0 scorecard

Changes effective Jan. 1.
(For more on CCI Version 22.0 edits, see story, p. 2.)

Code range	New pairs	Deleted pairs	Revised pairs
0001T - 0999T	8,286	555	0
00000 - 09999	2,685	806	0
10000 - 19999	1,570	727	0
20000 - 29999	4,837	3,492	0
30000 - 39999	5,054	2,521	5
40000 - 49999	11,376	3,971	36
50000 - 59999	5,318	2,302	57
60000 - 69999	4,607	1,992	14
70000 - 79999	5,439	1,613	0
80000 - 89999	5,815	101	0
90000 - 99999	1,873	588	2
A0000 - V9999	301	2,174	15
Totals	**57,161**	**20,842**	**129**

Note: Code range is based on the comprehensive code of the edit.
Source: Part B News *analysis of CCI 22.0 changes.*

NOTE: Part B News did not release a 21.3 scorecard effective October 1st, 2015.

NOTE: Part B News did not release a 21.2 scorecard effective July 1st, 2015.

[033115 NCCI Changes Effective April 2015]
Version 21.1 effective April 1st, 2015

CCI Version 21.1 scorecard

Changes effective April 1.
(For more on CCI Version 21.1 edits, see story, *PBN 3/16/15.*)

Code range	CCI code pairs added	CCI code pairs deleted
0001T - 0999T	1	0
00000 - 09999	0	0
10000 - 19999	0	0
20000 - 29999	722	0
30000 - 39999	165	0
40000 - 49999	30	0
50000 - 59999	0	0
60000 - 69999	41	0
70000 - 79999	3	0
80000 - 89999	74	0
90000 - 99999	11	18
A0000 - V9999	59	0
Totals	1,106	18

Note: Code range is based on the comprehensive code of the edit.
Source: Part B News *analysis of CCI 21.1 changes.*

[022315 NCCI Changes Effective January 2015]
Version 21.0 effective January 1st, 2015

CCI Version 21.0 scorecard
Changes effective Jan. 1.

Code Range	CCI Code Pairs Added	CCI Code Pairs Deleted
0001T - 0999T	1,039	2,848
00000 - 09999	1,623	911
10000 - 19999	1,890	269
20000 - 29999	12,901	3,419
30000 - 39999	11,910	1,201
40000 - 49999	5,514	2,709
50000 - 59999	4,216	4
60000 - 69999	6,346	3,294
70000 - 79999	1,302	2,622
80000 - 89999	11,469	112
90000 - 99999	2,533	429
A0000 - V9999	4,507	1,390
Totals	65,250	19,208

Note: Code range is based on the comprehensive code of the edit
Source: Part B News analysis of CCI **21.0** changes.