MEDDATA SERVICE BUREAU | MEDTRON SOFTWARE INTELLIGENCE

053117 NEWS BLAST

ATTENTION PROVIDERS
QUARTERLY UPDATES
NATIONAL CORRECT CODING INITIATIVE (NCC/CCI)
VERSION 23.0 and 23.1

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.

Version 23.0, Changes Effective January 1, 2017
The most pronounced edits found in CCI version 23.1 impact new 2017 CPT codes, including 14 new code bundles into non-face-to-face prolonged services, smoking cessation, and health risk assessment codes.

Prolonged Service Codes (99358 and 99359) are bundled to include supervision codes 99339-99340; anticoagulation management codes 99363-99364; medical team conference codes 99366-99367; home health supervision codes 99374-99375; hospice supervision codes 99377-99378; nursing facility codes 99379-99380; and online Evaluation & Management service code 99444 *(99444 is not covered by Medicare)*. (+ = add on code, i.e., list separately in addition to code for primary procedure)

- 99358 (prolonged evaluation and management service before and/or after direct patient care; first hour)
- 99359+ (prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes)

Health Risk Assessment (HRA) codes 96160 Administration of patient-focused HRA instrument with scoring and documentation, per standardized instrument) and 96161 (Administration of caregiver-focused HRA instrument for the benefit of the patient, with scoring and documentation, per standardized instrument) have new billing restrictions.

The codes below are notated with a "1" modifier indicator, which requires a modifier to override the bundle edit provided medical necessity can be proven.

- 96110 (Developmental screening);
- 99173 (Visual acuity screen);
- 96125 (Standardized thought processing testing, interpretation, and report per hour);
- 96127 (Brief emotional/behavioral assessment [e.g., depression inventory, attention-deficit/hyperactivity disorder {ADHD} scale], with scoring and documentation, per standardized instrument);
- 96150 (Health and behavior assessment each 15 minutes);
- 96151 (Health and behavior re-assessment each 15 minutes).

Other codes are bundled with HRA codes notated with a "0" modifier indicator, which restricts billing on same-day.
These include Health and behavior intervention codes 96152-96155; 96523 (Irrigation of implanted venous access drug delivery device); 99091 (Collection and interpretation of physical parameters stored in computers minimum of 30 minutes); and Ocular function screen 99172 (Automated or semi-automated visual function screening of both eyes).

Smoking Cessation (99406, 99407) and G codes below have '0' modifier indicator, which restricts billing on same day.
The G codes include follow-up inpatient consultation codes G0406, G0407 and G0408; Telehealth consultation codes G0425, G0426 and G0427; and Telehealth medication management code G0459.

Version 23.1, Changes Effective April 1, 2017

The most pronounced edits found in CCI version 23.1 are regarding additional edits on non-face-to-face prolonged services, injection code bundles, and a revised limit on cerumen-removal coding.

Prolonged Services

CMS is trying to establish a check on medical necessity by limiting non-face-to-face prolonged services.
The maximum amount of time allowed for codes 99358 and 99359 is two-hours. Providers are eligible to bill a full hour of non-face-to-face care with code 99358 and two units of 99359 for a total of 120 minutes (two hours).
If billing both codes for the maximum allowed time, providers can expect to see a gain of about $223.00.

In addition, there are several codes (see chart pictured) that cannot be reported with prolonged service visits 99354 and 99355.

Source: Part B News, March 13, 2017 Volume 31, Issue 11

Code	Descriptor
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	…; greater than 30 minutes
99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	…; each additional 30 minutes (List separately in addition to code for prolonged service)
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	…; 11-20 minutes of medical consultative discussion and review
99448	…; 21-30 minutes of medical consultative discussion and review
99449	…; 31 minutes or more of medical consultative discussion and review
99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
G0102	Prostate cancer screening; digital rectal examination
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	…, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	…, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	…, typically 30 minutes communicating with the patient via telehealth
G0426	…, typically 50 minutes communicating with the patient via telehealth
G0427	…, typically 70 minutes or more communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

Source: DecisionHealth analysis of CCI 23.1 PTP edits

Injection Codes

There are roughly 37,000 new code pairs on the do-not-bill list which are mostly bundled with one of seven injection codes.
CMS attributes these with a "0" modifier indicator which restricts billing on the same-day.
The seven codes are: (+ = add on code, i.e., list separately in addition to code for primary procedure)

- 64462+ (paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed))
- 64480+ (injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level))
- 64484+ (injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level))
- 64491+ (injection(s), diagnostic or therapeutic agent, paravertebral facet (zygaphphyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic, second level))
- 64492+ (injection(s), diagnostic or therapeutic agent, paravertebral facet (zygaphphyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic, third or any additional level(s))
- 64494+ (injection(s), diagnostic or therapeutic agent, paravertebral facet (zygaphphyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, second level))
- 64495+ (injection(s), diagnostic or therapeutic agent, paravertebral facet (zygaphphyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, third or any additional level(s))

There are some exceptions as long as medical necessity can be proven. One example is code 20552 (injections of trigger points in 1 or 2 muscles) and 20553 (injections of trigger points in 3 or more muscles). These codes and all of the injection codes listed above *except* 64462 are notated with a "1" modifier indicator, which means codes 20552 and 20553 are eligible to report with the transforaminal epidural codes and paravertebral facet injection codes on the same date of service, but will require a modifier to override the bundle edit provided medical necessity can be proven.

Cerumen Removal

Code 69209 (removal impacted cerumen using irrigation/lavage, unilateral) can only be reported *once* per patient per day. This change is most likely due to the common practice of medical offices billing 69209 with modifier 50 when removing impacted cerumen from a patient's right and left ear. Medicare will automatically deny a claim submitted with 69209 billed twice on the same date of service.

Chronic Care Management

Code G0506 (comprehensive assessment of and care planning for patients requiring chronic care management services) is **not** allowed to be billed with codes 99358 and 99359 for non-face-to-face prolonged services. G0506 has a "0" modifier indicator with codes 99354-99357, 99358, and 99359 which restricts billing on same-day.

Deleted Code Pairs

A number of code pairs have been deleted meaning the code pairs are no longer notated with a "0" modifier indicator.

- 99495 and 99496 (transitional care management (TCM) services) and G0179 (physician re-certification for Medicare-covered home health services under a home plan of care) and G0180 (physician certification for Medicare-covered home health services under a home plan of care)
- 96160 and 96161 (health risk assessment (HRA)) and several hospital codes which include codes 99218-99220 (observation) and 99221-99223 (inpatient services)
- 96160 and 96161 (HRA) and 99408 and 99409 (alcohol and substance abuse screening codes)

Score Card:

CCI Version 23.0 scorecard

Changes effective January 1.

(For more on CCI Version 23.0 edits, see story, p. 1.)

Code range	CCI code pairs added	CCI code pairs deleted
0001T - 0999T	7,924	2,543
00000 - 09999	4,348	3,520
10000 - 19999	4,131	2,833
20000 - 29999	22,403	12,978
30000 - 39999	19,889	11,065
40000 - 49999	10,495	6,492
50000 - 59999	9,016	5,107
60000 - 69999	12,865	6,644
70000 - 79999	988	560
80000 - 89999	946	469
90000 - 99999	5,706	2,713
A0000 - V9999	779	819
Totals	**99,490**	**55,743**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI 23.0 changes.*

CCI Version 23.1 scorecard

Changes effective April 1.

(For more on CCI Version 23.1 edits, see Part B News)

Code range	CCI code pairs added	CCI code pairs deleted
0001T - 0999T	19	48
00000 - 09999	1	0
10000 - 19999	2,395	0
20000 - 29999	10,983	0
30000 - 39999	6,375	39
40000 - 49999	5,715	7
50000 - 59999	4,930	0
60000 - 69999	5,558	7
70000 - 79999	43	0
80000 - 89999	387	3
90000 - 99999	694	23
A0000 - V9999	112	57
Totals	**37,212**	**184**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI 23.1 changes.*

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