National Correct Coding Initiative Affects CPT Reporting

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Since 1996, the Health Care Financing Administration (HCFA) has used CPT edit tables installed in the Medicare Part B claims processing systems to determine incorrect and inappropriate reporting of code combinations for Part B services including physician services. These edits are expected to be applied to facilities reporting CPT codes for outpatient services in anticipation of the Ambulatory Payment Classification (APC) prospective payment system (PPS) to be implemented later this year. With approval from HCFA, administrator AdminaStar Federal has developed, refined, and maintained the edits as a contractor since 1994. This contract expires in September 2000. Quarterly updates to these edits are planned for April and July 2000, with a possible fourth update in October when the new contract is awarded.

The purpose of the edits is simple: to prevent payments from being made in error due to inappropriate CPT code assignments.

The Correct Coding Initiative (CCI) edit file is a front-end table of CPT-4 codes within the Medicare Part B claims processing systems. The table consists of code pairs or "edits" separated in two columns. Column one contains the correct code, while column two contains the incorrect or inappropriate code in relation to the code in column one.

The result is that Medicare pays for the column one code and denies payment for the column two code. Modifiers may be added to explain the circumstances of the procedures performed when there is a valid reason why separate reimbursement might be warranted.

The original edits were created from HCPCS/CPT4 coding manuals and an analysis of Medicare claims data. They included existing national rebundling edits that were in use prior to CCI development. National medical review and coverage policies were also a source of edits.

As the CCI continues, edits are updated in accordance with changes in the code systems and any coding guidelines published by national physician specialty societies or other authorized sources. Providers are encouraged to contact AdminaStar Federal, Inc., in writing if there is disagreement about a bundled procedure. The provider should be prepared to provide the HCPCS/CPT codes in question and the justification for the proposed change, such as clinical medical literature, studies, standards of medical practice, national medical policy, national specialty society/association coding guidelines, and the American Medical Association's coding advice as found in *CPT Assistant*.

First Physicians, Now Hospitals

Since 1996, Medicare has saved more than $700 million from using the edits for physician and ambulatory surgical centers. When the APC program is implemented, these edits will also apply to hospital outpatient claims.

One of the purposes of the CCI is to ensure that the most comprehensive group of codes is billed instead of the component parts. For example, G0001 (routine venipuncture) is a component part of 36430 (transfusion of blood or blood components) and should not be separately billed, according to an edit published in the Sept. 8, 1998, *Federal Register*. Similarly, 94760 (pulse oximetry) should not be billed with surgical procedures for which it is a common monitoring technique. In 1997, that code appeared more than 10,000 times in hospital outpatient claims with 45378 (diagnostic colonoscopy). The CCI also checks for coding that has "with" and "without" code pairs. For example, 93797 (cardiac rehabilitation without ECG monitoring) should not be billed simultaneously with 93798 (cardiac rehabilitation with ECG monitoring), which happened nearly 12,000 times in 1997 hospital outpatient claims.

Medicare carriers have used the CCI as an editing tool for physician claims since January 1996 and have discovered that the vast majority of edits are rarely triggered. However, as shown in the examples above, hospitals' coding patterns could result in inappropriate payments unless such edits are applied. Under the cost reimbursement system, neither these types of errors nor providing wrong numbers in the units field (for example, repeating the revenue code) ultimately resulted in higher payments to the hospitals. Again, under this PPS, each unit billed will trigger a payment.

HCFA then created a second set of edits limiting the number of units allowed for each HCPCS code. For example, only "1" will be accepted in the units field for cataract surgery, but for most services the edit allows the procedure to be performed several times in a day, with an upper limit to reduce obvious errors. Of course, hospitals should report only the actual number of times a procedure was performed, keeping in mind that HCPCS definitions sometimes specify the units. For example, code 11720 is for debridement of nail(s) by any method; one to five. This code should be reported only once for any number of nails debrided between one and five, inclusive. If more than five nails are debrided, the appropriate code is 11721, debridement of nail(s) by any method; six or more, billed only once in place of 11720.

If each of the procedures listed in a CCI edit are performed by two different physicians in a clinic of different specialties, whether hospital-based or not, both will be considered for payment. The criteria that must be met for the bundling to occur is the services are provided for the same beneficiary/patient, on the same date of service, by the same performing provider. However, there may be other national or local carrier policies in place that would not allow both physicians from the same group to be paid in certain situations.

Modifiers and the NCCI

There are 35 correct coding modifiers that are allowed with a portion but not all of the CCI edits. These include the anatomical modifiers of -E1, -E4, -FA, -F1, -F9, -LC, -LD, -LT, -RC, -RT, -TA, T1, and T9; the global surgery modifiers of -25, -58, -78, -79; and other modifiers -91 and -59.

If you determine that one of these modifiers is appropriate to describe a service, it should usually be attached to the procedure that is bundled (the component/column two code), although it may be attached to either code of the code pair, but not both. This explains a circumstance where both services should be paid. Because different dates of service or different rendering physicians do not meet the criteria for bundling in CCI, no modifier is required to indicate different days to different physicians. However, coding guidelines dictate that if a modifier adds more information to the code being billed, it should be used.

To distinguish separate patient encounters on the same day, the global surgery modifiers -58, -78, and -79 may be used for physician reporting. Also modifier -91 may be used for laboratory test reporting. If none of the previously mentioned modifiers apply, then modifier -59 can be used to indicate a separate patient encounter or a distinct and separate site.

Reference

"National Correct Coding Initiative: Impact on Physician Coding Practice." AHIMA Audio seminar conducted on November 4, 1999, Chicago, IL.

A complete copy of the NCCI edits is available from the National Technical Information Service (NTIS) at (800) 363-2068 or orders@ntis.fedworld.gov. For more information, visit www.ntis.gov.

For information about the National Correct Coding Initiative, contact AdminaStar Federal, Inc., P.O. Box 50469, Indianapolis, IN 46250-0469, Attention Niles R. Rosen, MD, or Linda Dietz, RHIA, CCS, CCS-P; fax: (317) 841-4600.

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