National Correct Coding Initiative: A Valuable Resource in Outpatient Coding Compliance

By Suzanne P. Drake, RHIT, CCS

The organizations health information management professionals serve are reliant on their understanding of outpatient coding and reporting conventions to ensure that the reimbursement received by facilities is accurate and not subject to improper payment audits.

The National Correct Coding Initiative (NCCI) is a helpful tool for maintaining coding and reporting compliance. A free resource, NCCI is available on the Centers for Medicare and Medicaid Services' (CMS) website. The tool was developed to mitigate improper coding and payments to Medicare outpatient Part B claims. The NCCI manual is updated annually and is published in chapters that are in alignment with the chapters and conventions of the American Medical Association's (AMA's) Current Procedural Terminology (CPT) coding system for that same year.

The content of the CPT system serves as the basis for NCCI edits involving comprehensive and component service pairs. It helps to establish what components of a procedure are packaged and not reported separately, illustrates examples that provide guidance on when it is appropriate or inappropriate to report separate procedures, and provides insights into Medically Unlikely services.

General Policy Guidelines Included in the NCCI

Chapter one of the NCCI manual provides the platform for all subsequent chapters in the manual and discusses some recurrent policy provisions that should be applied in most instances.

CMS clarifies that their use of the term "physician" in the National Correct Coding Policy and Procedure Manual is intended to be applied to all healthcare "practitioners, hospitals, providers, or suppliers eligible to bill with HCPCS."

Commensurate with the CPT Surgical Package Definition in the CPT manual, CMS also provides a list of services that are considered to be integral to the surgical package.

One element listed as a part of the surgical package in the NCCI manual includes the verbiage that "debridement of traumatized tissue" and "lysis of adhesions" are part of the surgical package.

This guidance regarding the lysis of adhesions is consistent throughout the NCCI manual.

Chapter six, which covers the digestive system, notes that open lysis of adhesions (44005) and laparoscopic lysis of adhesions (44200) are both designated as "separate procedures" which "should not be reported in addition to the code for the total procedure or service," per the CPT manual. A separate lysis procedure can be reported separately only in instances that the surgeon performs and documents "an extensive and time consuming" lysis procedure performed in conjunction with another procedure.

With regard to laparoscopic lysis of adhesions, chapters six, seven, and eight of the NCCI manual all state that it is not appropriate to report a laparoscopic lysis of adhesions separately when any "other surgical laparoscopic procedure" has been performed.

Guidance involving debridement services is also consistent in the manual. In most instances, even when the debridement is performed to remove diseased tissue at the surgical access site, the debridement is considered integral to the total service and would not be reported separately. See chapters three and four for additional discussions involving the reporting of debridement procedures, and note examples of when the reporting of a separate debridement procedure is allowed.

Other Notable Guidance Available from the NCCI

Each chapter of the NCCI manual contains extensive discussions and guidance on appropriate reporting for the specific CPT code range/chapter represented.

Some useful guidance that is discussed across multiple chapters and applies to multiple services includes:

- "Scout" procedures are discussed in multiple chapters of the NCCI manual including chapters one and four through nine for surgical and radiological scout procedures. Each chapter notes that scout procedures performed prior to another procedure to assess the surgical field and visualize the anatomic landmarks are not reported separately.
- If a biopsy of a lesion is performed, and then a more extensive procedure is performed at that same site, the biopsy procedure cannot be reported separately unless that biopsy result was the determining factor used by the physician to perform the more extensive procedure. This guidance is repeated in almost every chapter of the NCCI manual.
    - If a biopsy of one lesion is performed and a more extensive procedure is performed on a separate lesion, both services can be reported. One good example is a colonoscopy with biopsy of one lesion, then polypectomy of another. In that instance both the biopsy and the polypectomy would be appropriate to report.
- The use of multiple approaches to complete the same procedure should not be reported separately. One example provided in chapter one of the manual includes a vaginal and abdominal hysterectomy. Chapters four and six also have detailed discussions involving arthroscopic and laparoscopic procedures converted to open procedures, and in keeping with this provision instruct that only an open procedure should be reported in these instances.
- Complications that occur during the primary surgical procedure can sometimes be reported; but, caution the reader, the surgical package includes all of the services necessary to perform a procedure, including the postoperative period. If the complication results in the performance of an additional procedure significantly outside of the scope of the planned procedure, that additional procedure would be appropriate to report. However, if the procedures performed to treat the complication are usual and customary components of the primary service, or if a complication occurs postoperatively but does not require a return to the operating room, the procedure should not be reported separately. One example discussed in multiple chapters is the control of a postoperative hemorrhage. If the control of the hemorrhage does not require a return to the operating room, the service would not be reported separately.

NCCI Coding Edits and Tables

In addition to the NCCI manual, CMS provides NCCI Coding Edit Tables on their website. The tables provide helpful guidance in determining if certain code pairs are appropriate to report together for both hospitals and physicians.

There are two tables each for hospitals and physicians, each table encompassing a code range to manage the size of the files. The physician tables are appropriate for use by physician and non-physician healthcare providers, as well as ambulatory surgical centers. The hospital tables are appropriate for use by hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities.

Note that each procedure code will be listed as many times as there is a secondary code associated with that primary code in which an NCCI edit exists. For example, HCPCS code A4263 is listed only once in Column A, with only one code pair. In contrast, CPT code 40490 is listed in Column A 154 times, with a different component code listed in Column B on each different line.

When using the tool, first find the primary procedure in Column A, then scroll through to see if the secondary/component procedure is listed in Column B.

If the secondary procedure is not listed, it means that no NCCI edit exists for the pair, and both procedures could be reported.

When the secondary procedure is listed, look to Column F to see what modifier exists for that pair. There are three possible modifiers that will appear in Column F: 0, 9, or 1. In instances that the modifier is "0," under no circumstance should this pair be reported. Even if a modifier is applied to the secondary procedure, the secondary procedure will not be paid. When the modifier is "9," the NCCI edit does not apply to this code pair and "the edit for this code pair was deleted retroactively."

In instances when the modifier is reflected as "1," there are circumstances that this pair could be reported together using an appropriate modifier to indicate that the procedure was separate in nature and should be paid separately.

Make certain that it is correct to report modifier 59 or one of the expanded –X {EPSU} modifiers to the Column B procedure before appending. Improper reporting of modifier "59" has been identified as a compliance issue since the reporting of modifier 59 results in additional reimbursement to the facility. See Transmittal 1422 for additional discussions.

The CPT manual defines a separate procedure as one that involves "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

To circumvent misuse of modifier 59, CMS developed a subset of modifier 59 referred to as the –X {EPSU} modifiers that went into effect January 1, 2015. Those modifiers include XE to report a separate encounter, XS to report a separate structure, XP to report a separate practitioner, and XU for unusual overlapping procedures.

The NCCI manual and Edit tables have tremendous value in assisting all healthcare settings in the prevention of reporting improper claims. Review those chapters that are applicable to the services being coded to ensure compliance in the reporting of comprehensive and component service pairs.

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Suzanne P. Drake (Suzanne_Drake@Bshsi.org) is coding quality and RAC coordinator at Bon Secours Health System, based in Richmond, VA.

Article citation:
Drake, Suzanne P. "National Correct Coding Initiative: A Valuable Resource in Outpatient Coding Compliance" *Journal of AHIMA* 86, no.5 (May 2015): 68-70.