Navigating Claim Edits

NCCI, MUE, Modifiers

iRi Integrated Revenue Integrity

Jon Menard, CPC, COC, CHFP
Principal Consultant

September 15, 2022

Agenda

- National Correct Coding Initiative (NCCI) Program
- Rationale behind NCCI and MUE Edits
- Proper resolution of claim edits with modifiers

National Correct Coding Initiative (NCCI)

- CMS established the National Correct Coding Initiative (NCCI) program in 1996
- The program contains three types of edits:
  - Procedure to Procedure (PTP) edits
  - Medically Unlikely Edits (MUES) (added to program January 2007)
  - Add-on code edits
- The purpose of the program is to promote national correct coding methodologies and prevent inappropriate payments

Procedure to Procedure (PTP) edits

- Used to prevent improper payments when incorrect code combinations are reported
- Two different lists of NCCI edits exist – one for physicians/practitioners and one for outpatient hospital services
- Physician/practitioner file also applies to Ambulatory Surgical Centers (ASCs)
- Each contains two columns of codes identifying code pairs that in general, should not be reported together

Procedure to Procedure (PTP) edits

- Determinations of code pairs which should not be reported together are made based on coding conventions defined by:
  - The American Medical Association (AMA) CPT Manual
  - National and local policies
  - Coding guidelines developed by national societies
  - Analysis of standard medical and surgical practices
  - Review of current coding practices

Procedure to Procedure (PTP) edits

- Each PTP edit has a column one and column two CPT/HCPCS code
- If a both codes of an edit pair are reported for the same beneficiary on the same date of service, the column one code is eligible for payment and the column two code is denied
- For some code pairs, a **clinically appropriate** NCCI-associated modifier may be reported to bypass the edit and allow payment for the column two code
- These code pairs are identified via the “modifier indicator” in the NCCI edit file

Modifier Indicator

- Each code pair has a modifier indicator which indicates if the edit may be bypassed with the use of an appropriate modifier

- Modifier indicator 0 = **Not Allowed**
- Modifier indicator 1 = **Allowed**
- Modifier indicator 9 = **Not Applicable** (due to edit being discontinued)

Example: Colonoscopy with biopsy - 45379

Column 1	Column 2	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
45379	45378	19970101	*	0	CPT "separate procedure" definition
45379	45382	19960101	*	1	Standards of medical / surgical practice

- Diagnostic colonoscopy (45378) is not reportable on same claim, and modifier is not allowed to bypass edit
- Colonoscopy with control of bleeding (45382) is not reportable on same claim, unless reported with appropriate modifier

NCCI Edit Rationales

- Standards of Medical/Surgical Practice
- Mutually exclusive procedures
- Standard preparation/monitoring services for anesthesia
- HCPCS/CPT procedure code definition
- CPT manual or CMS manual coding instruction
- Sequential procedure

NCCI Edit Rationales

- CPT “Separate Procedure” definition
- More extensive procedure
- Gender-specific procedures
- Anesthesia service included in surgical procedure
- Laboratory panel
- Misuse of column two code with column one code

Standards of Medical/Surgical Practice

- Most HCPCS defined procedures include services that are integral to them
- Services that are integral to a HCPCS defined procedure are included in those procedures based on the standards of medical/surgical practice
- It is inappropriate to separately report services that are integral to another procedure
- Many NCCI PTP edits are based on this standard
- The comprehensive procedure is placed in column one of the edit file and the component service in column two

Standards of Medical/Surgical Practice

The following general principles are applied to determine these edits:

1. The component service is an accepted standard of care when performing the comprehensive service

2. The component service is usually necessary to complete the comprehensive service

3. The component service is not a separately distinguishable procedure when performed with the comprehensive service

Standards of Medical/Surgical Practice

Examples:

1. Many invasive procedures require vascular or airway access, which is not separately reported (e.g., contrast imaging exams, anesthesia)

2. Excision and removal (-ectomy) procedures include the incision and opening (-otomy)

3. Many procedures require cardiopulmonary monitoring, which is not separately reportable (e.g., cardiac monitoring, pulse oximetry, ventilation management)

Standards of Medical/Surgical Practice: Examples

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
74177	96374	20120701	*	1	Standards of medical / surgical practice
92960	93005	20080701	*	1	Standards of medical / surgical practice

- Injection of contrast material is an inherent component of CT exams with contrast – 96374 should not be separately reported for the contrast administration
- EKG monitoring is an inherent component of cardioversion – 93005 for EKG tracing should not be reported for the related monitoring

Mutually Exclusive

- Many procedure codes cannot be reported together because they are mutually exclusive of each other
- Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter
- Some mutually exclusive edits cannot be bypassed with a modifier, as the codes would be impossible to perform together
- Others may be bypassed with modifiers if documentation supports the procedures as being performed at distinct sites, encounters, etc.

Mutually Exclusive: Examples

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
94002	94003	20070101	*	0	Mutually exclusive procedures
Q9967	Q9965	20180401	*	1	Mutually exclusive procedures

- CPT 94002 for ventilation management, initial day, would never be reported on the same claim as CPT 94003 for ventilation management, subsequent day under any circumstances.
- Q9967 and Q9965 describe two different contrast materials. Generally, only one contrast material will be used. If two different contrast materials for two different procedures were required, edit could be bypassed.

HCPCS/CPT Procedure Code Definition

- The code descriptor of a HCPCS/CPT is often the basis of an NCCI edit
- Examples:

1. Families of CPT codes often include a CPT code followed by one or more indented codes. The first CPT code descriptor includes a semicolon. The portion of the descriptor of the first code in the family preceding the semicolon is a common part of the descriptor for each subsequent code of the family.
2. Code descriptions often define components of the procedure that may not be reported separately (e.g., “including, when performed”)

HCPCS/CPT Procedure Code Definition: Examples

Column 1	Column 2	Effective Date	Deletion Date	Modifier 0=not allowed	PTP Edit Rationale
			*=no data	1=allowed	
11451	13100	19960101	*	1	HCPCS/CPT procedure code definition
76818	59025	20020401	*	1	HCPCS/CPT procedure code definition

- The description of CPT 11451 for an excision procedure states that it includes complex repair, so complex repair (13100) is not separately reportable
- The description of CPT 76818 is a fetal biophysical profile with non-stress testing, so non-stress testing (59025) is not separately reportable when performed with the biophysical profile

CPT or CMS Manual Coding Instruction

- CMS often publishes coding instructions in its rules, manuals, and notices

- The CPT manual includes coding instructions found in the introduction section of individual chapters and appendices, as well as at the beginning of many chapter subsections or before specific families of CPT codes

- Parenthetical guidelines also provide additional guidance for many codes in the CPT manual

CPT or CMS Manual Coding Instruction: Examples

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
88360	88341	20151001	*	1	CPT Manual or CMS manual coding instructions
90791	99283	20201001	*	1	CPT Manual or CMS manual coding instructions

- Parenthetical guideline beneath CPT 88360 in the CPT manual states:

(Do not report 88360, 88361 in conjunction with 88341, 88342, or 88344 unless each procedure is for a different antibody)

- Introductory coding guidelines for psychiatric diagnostic procedures state:

Codes 90791, 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient.

Sequential Procedure

- Some surgical procedures may be performed by different surgical approaches
- If an initial surgical approach to a procedure fails and a second surgical approach is used at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported
- If there are different HCPCS/CPT codes for the two different surgical approaches, the two procedures are considered “sequential,” and only the HCPCS/CPT code corresponding to the second surgical approach may be reported
- Example: laparoscopic procedure converted to open procedure is reported only with code for open procedure

CPT "Separate Procedure" Definition

- If a CPT code descriptor includes the term "separate procedure," the CPT code may not be reported separately with a related procedure
- CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach
- A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate encounter or at the same encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach

CPT "Separate Procedure" Definition: Examples

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
52287	76000	20130101	*	1	CPT "separate procedure" definition
93312	43191	20140101	*	1	CPT "separate procedure" definition

- 76000: Fluoroscopy (**separate procedure**), up to 1 hour physician or other qualified health care professional time
- 43191: Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (**separate procedure**)

More Extensive Procedure

- The CPT Manual often describes groups of similar codes differing in the complexity of the service
- Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable
- Examples: for two procedures defined as “simple” and “complex” or “limited” and “complete” or “superficial” and “deep,” only the more extensive procedure is reported, unless performed at separate encounters or at separate anatomic sites

Laboratory Panel

- The CPT Manual defines organ and disease specific panels of laboratory tests

- If a laboratory performs all tests included in one of these panels, the laboratory must report the CPT code for the panel

- If the laboratory repeats one of the component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 (repeat laboratory test) appended

Laboratory Panel: Example

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
80048	82947	20000605	*	1	Laboratory panel

- Per the CPT manual, a basic metabolic panel (80048) consists of the following tests:
  - Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565) ,Glucose (82947), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)
- Panel components may not be unbundled and reported individually
- If a repeat glucose test (82947) was ordered and performed in addition to the panel, the code could be reported with modifier 91 to bypass the edit

Misuse of Column Two Code with Column One Code

- CMS manuals and instructions often describe groups of CPT/HCPCS codes that should not be reported together under the Medicare program
- Edits based on these instructions are often included as “misuse of a Column Two code with a Column One code”
- Code descriptors do not include exhaustive information about the code and a CPT/HCPCS code may be incorrectly reported in a context different than intended – commonly misused codes have also been assigned these edits

Misuse of Column Two Code with Column One Code: Examples

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
85025	85007	19990101	*	0	Misuse of column two code with column one code
93976	76700	20040101	*	1	Misuse of column two code with column one code

- CBC w/ auto diff (85025) may not be reported with manual differential (85007) due to CMS rule that they will not pay for the same result performed by two different methodologies unless medically necessary
- Duplex exams and ultrasound exams may only be reported together if each is medically reasonable and necessary (usually performed for different indications)

Misuse of Column Two Code with Column One Code

- There may be scenarios where the codes are being used appropriately and the modifier may be bypassed
- Example:

  Three or more HCPCS/CPT codes may be reported on the same date of service. Although the Column Two code is misused if reported as a service associated with the Column One code, the Column Two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service

Example Revisited: Colonoscopy with biopsy - 45379

Column 1	Column 2	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed	PTP Edit Rationale
45379	45378	19970101	*	0	CPT "separate procedure" definition
45379	45382	19960101	*	1	Standards of medical / surgical practice

- Diagnostic colonoscopy (45378) is not reportable on same claim because this CPT is defined as a “separate procedure” and would never be unrelated to the biopsy procedure
- Colonoscopy with control of bleeding (45382) is not reportable on same claim if performed as part of the standards of medical/surgical practice (e.g., to control the bleeding of a lesion that was biopsied).

NCCI Coding Policy Manual

- General reference tool that explains the rationale for NCCI edits
- Updated annually and available for download on the CMS website
- Helpful in determining the appropriate next steps when NCCI edit is triggered
- Broken into chapters for various sections of CPT/HCPCS codes (e.g., Chapter 6 covers edits applicable to CPT codes in the 40000-49999 range).

Example: Lipid Panel with Direct LDL Measurement

Column 1	Column 2	Effective	Deletion	Modifier	PTP Edit Rationale
		Date	Date	0=not allowed	
			*=no data	1=allowed	
				9=not applicable	
80061	82465	19960101	*	0	Laboratory panel
80061	83718	19960101	*	0	Laboratory panel
80061	83721	20030401	*	1	Misuse of column two code with column one code
80061	84478	19960101	*	0	Laboratory panel

NCCI Policy Manual, Chapter 10, Section G (1)

1. CPT code 83721 (Lipoprotein, direct measurement; LDL cholesterol) describes direct measurement of LDL cholesterol. It shall not be used to report a calculated LDL cholesterol.

- Should modifier be appended to bypass this edit?
- Need to confirm that direct measurement code is not being reported for the automated calculation, and that the charge is supported (separate order, documentation, etc.)
- Manual previously stated that direct measurement in addition to lipid panel may be reasonable and necessary if triglyceride level was over 400 mg/lg and to report 83721 with modifier 59 in this case

NCCI Coding Policy Manual

- Tip: Each year, new text added to the manual is written in red font
- Download new file each year and scan through red text to get familiarized with coding policy updates
  - Example: 2019 NCCI Coding Policy Manual, Chapter 10, Section F (8)

If one laboratory procedure evaluates multiple genes utilizing a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure, molecular multianalyte assay, multianalyte assay with algorithmic analysis, or proprietary laboratory analysis CPT code. If no CPT code accurately describes the procedure performed, the laboratory shall report CPT code 81479 (unlisted molecular pathology procedure) with one unit of service. The laboratory shall not report multiple individual CPT codes describing the component test results. If a single procedure is performed, only one HCPCS/CPT code with one unit of service may be reported for the procedure.

NCCI Updates

- NCCI files are updated quarterly to account for changes in code sets, technology, medical practice, and input from the AMA and other organizations

- Edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist

- *Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination*

Example: Blood Draws from VADs or CVCs

- NCCI Manual, Chapter 9, Section H (23)

CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous, not otherwise specified." These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

Medically Unlikely Edits (MUEs)

- MUEs for CPT/HCPCS codes represent the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service

- The purpose of the MUE program is to prevent improper payments when services are reported with incorrect units of service

- MUE values are based on code descriptions, CPT instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyte, nature of equipment, prescribing information, clinical data

Medically Unlikely Edits (MUEs)

- Three lists of edits are updated quarterly – one for physicians, one for outpatient hospital services, and one for DME suppliers
- Not every CPT/HCPCS code has an MUE assigned.
- Not all MUEs that are assigned are published
  - Confidential MUEs are for Medicare contractor use only & may not be distributed
  - CMS feels that certain codes are more vulnerable to fraud and abuse if values were to be published
- MUE values are not utilization guidelines, and do not represent units of service that may be reported without concern about medical review

Medically Unlikely Edits (MUEs)

- In 2013, CMS expanded the MUE program to include date of service (DOS) edits in addition to line item edits
- For line item edits, units of service (UOS) on each claim line are compared to the MUE value for the CPT/HCPCS code on the claim line
- If the UOS exceed the MUE value, all UOS on that claim line are denied
- For DOS edits, all units on each claim line for the same DOS are summed, and the summed value is compared to the MUE value
- If the summed UOS exceed the MUE, all UOS for the HCPCS code for that DOS are denied

Medically Unlikely Edits (MUEs)

- Similar to PTP edits, the MUE file published by CMS lists the rationale behind each MUE edit
- Rationales include:
  - **Anatomic consideration** (e.g, patient only has one appendix, so MUE for appendectomy is one)
  - **Clinical guidelines** (e.g., what is determined to be reasonable and necessary to perform during a single encounter)
  - **CMS policy** (e.g., bilateral services must be reported with unit of 1)
  - **Code descriptors / CPT instructions** (e.g., code for “initial 30 minutes” or “per day” would have MUE of 1, or code for “biopsy(ies) would have an MUE of 1)

Medically Unlikely Edits (MUEs)

- Rationales include:
  - **Nature of analyte** (e.g., lab test where the result would not change during a single day would not be reported with more than 1 unit)
  - **Nature of service/procedure** (e.g., only one overnight sleep study can be performed per day, or some procedures would be rarely, if ever, performed more than once in a day, such as a colonoscopy)
  - **Nature of equipment** (e.g., for DME, patient would not need more than one wheelchair)
  - **Prescribing information** (e.g., drug could not be furnished in units greater than the maximum prescribing information)

Billing Units in Excess of MUE Values

- CMS states that “the ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE”
- On occasion, it may be medically reasonable and necessary to provide units of service in excess of the MUE value
- Each MUE edit is assigned an “MUE Adjudication Indicator” (MAI) in the MUE edit file
- This indicator determines if and how the edit may be bypassed or appealed

MAI 1 – Claim Line Edit

- MUE edits assigned an MAI of 1 are claim line edits
- These edits may be bypassed with an NCCI modifier, if appropriate
- Report up to the maximum MUE value on first line
- Report additional lines up to maximum MUE value with a modifier

Example - CPT 96365 “IV Infusion, Initial, 1 hr” has MUE of 1. If two separate IV access sites are needed, which would justify a second unit, report as:

260	96365	1
260	9636559	1

MAI 2 – Date of Service Edit - Policy

- MUE edits assigned an MAI of 2 are DOS edits that are absolute based on policy
- These may not be bypassed with modifiers and are not appealable
- CMS states that units in excess of the MUE value would be considered impossible due to statute, regulation, coding policy, anatomic limitations, etc.
- Example: 94002 “Ventilation assist and management … initial day”

  Absolute MUE of 1, as there could not be two “initial days” of management

MAI 3 – Date of Service Edit - Clinical

- MUE edits assigned an MAI of 3 are DOS edits based on clinical benchmarks
- Based on criteria that would make it possible, but medically highly unlikely, that higher values would correctly report medically necessary services
- Denials for these MUE edits may be appealed and can be overturned based upon clinical evidence of medical necessity
- Example: CPT 73620 for 2-view foot x-ray has clinical MUE of 2 – it would be rare/unlikely for a patient to require more than 2 foot x-rays in a day, but if it was medically necessary, this denial could be appealed

Add-on Code Edits

- Some CPT and HCPCS codes defined as “add-on” codes, which can only be reported in addition to a primary procedure
- Include the terminology “List separately in addition to code for primary procedure”
- An add-on code is eligible for payment only if one of its primary codes is reported on the same claim and is also eligible for payment
- CMS lists all add-on codes and their related primary codes that they are reportable with on the CMS website

NCCI Denials

- Services denied due to NCCI edits are coding denials, not medical necessity denials
- Presence of an ABN does not shift liability to the beneficiary
- Physicians *shall* not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

Modifiers to Bypass NCCI/MUE Edits

- Modifiers may be appended to CPT/HCPCS codes ***only if the clinical circumstances justify the use of the modifier***
- A modifier may not be appended to a CPT/HCPCS code solely to bypass an NCCI edit

Modifiers to Bypass NCCI/MUE Edits

- The following modifiers may be used to bypass NCCI edits under appropriate clinical circumstances:
  - Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
  - Global surgery modifiers: 24, 25, 57, 58, 78, 79
  - Other modifiers: 27, 59, 91, XE, XS, XP, XU
- Note: Modifiers 76 (repeat procedure or service by same physician) and 77 (repeat procedure by another physician) are not NCCI-associated modifiers and will not bypass an NCCI edit.

Resources

General NCCI Information –
https://www.cms.gov/medicare/coding/ncci-coding-edits
NCCI Policy Manual –
NCCI Policy Manual for Medicare | CMS
PTP Coding Edits –
PTP Coding Edits | CMS
MUE Edits –
Medically Unlikely Edits | CMS
Add-on Edits –
Add-on Code Edits | CMS

Questions?

jmenard@integratedri.com

info@integratedri.com