Solve NCCI Edits and MUEs

A WEBINAR PRESENTED ON JANUARY 18, 2023

NAHRI
National Association of Healthcare Revenue Integrity

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Presented By

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Define National Correct Coding Initiative (NCCI) edits and Medically Unlikely Edits (MUE)
  - Describe recent updates to the NCCI manual
  - Identify strategies for addressing the edits and solving root causes

Polling Question #1

- How does information in the NCCI Narrative Manual and information regarding the edits get communicated at your organization?
  - We have a process for downloading and sending the information to the appropriate departments or persons.
  - We let our coding team handle that information.
  - We learn about specifics when Compliance does an audit.
  - It's every person for him/herself.
  - I don't know.

National Correct Coding Edits and Why They Matter

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National Correct Coding Initiative

- The NCCI is a CMS-initiated program intended to:
  - "Encourage consistent and correct coding"
  - Reduce inappropriate payments
- The official *NCCI Manual* contains:
  - Descriptions of three types of edits:
    - Procedure-to-Procedure (PTP) edits
    - Medically Unlikely Edits (MUE)
    - Add-on code edits (AOC)
  - Policies that direct the correct coding of services:
    - May or may not agree with American Medical Association (AMA) coding policies
    - CMS instructions trump AMA instructions for Medicare if they are different

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National Correct Coding Initiative

- The *NCCI Manual* contains:
  - Explanations of edits and rationale upon which edits are based
  - Introduction describing the background, edit development, and review processes
  - Chapter 1 discusses general correct coding principles
  - Chapters 2–11 discuss codes, following the construction of the Current Procedural Terminology (CPT®) manual
  - Chapter 12 discusses Healthcare Common Procedure Coding System (HCPCS) Level II codes
  - Chapter 13 discusses CPT Category III codes
- The manual is updated annually. The manual and specific edit files can be accessed from the following link: *https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual*

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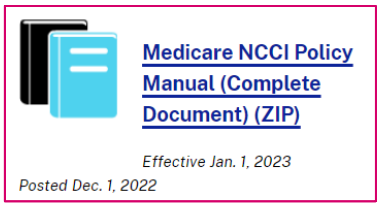
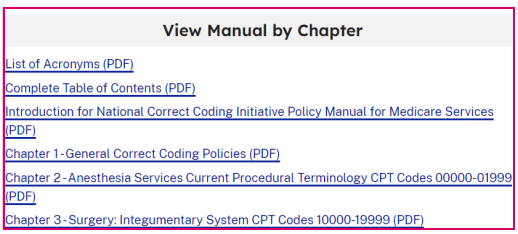
National Correct Coding Initiative

- Accessing the *NCCI Manual*





Excerpt from the webpage *https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual*

- Option to download the complete manual or select individual chapter(s)

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National Correct Coding Initiative

- This page also contains copies of previous years' NCCI narrative manual.

Archive

This archive contains past versions of the Medicare NCCI Policy Manual.

Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2022
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2021
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2020
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2019
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2018
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2017
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2016
Medicare NCCI Policy Manual (ZIP) - Effective Jan. 1, 2015

National Correct Coding Initiative

- Reminder from CMS in the *NCCI Manual*:
  - Many policies use the term "physician." However, this does not restrict the policies to only physicians, unless the manual indicates otherwise. The policies apply to all practitioners, hospitals, providers, or suppliers who bill the relevant HCPCS/CPT codes, based on the Social Security Act (SSA) of 1965, the *Code of Federal Regulations* (*CFR*), and Medicare rules regarding the applicable service(s).
  - CMS also acknowledges that in certain circumstances, the term "physician" does not apply to entities other than physicians/nonphysician practitioners as the specific rules do not apply. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.
  - When a service is denied due to a PTP edit, this does not make the service noncovered based on medical necessity. It is a coding denial because the code(s) cannot be reported with other codes on the claim, and the provider may not hold the beneficiary responsible for payment.

National Correct Coding Initiative

Procedure-to-Procedure (PTP) Edits

NCCI Procedure-to-Procedure (PTP) Edits

- PTP edits apply to certain pairs of codes for services provided:
  - To a single beneficiary
  - On a single date of service
  - By the same provider
- With respect to most code pairs subject to a PTP edit:
  - Only one code should be billed
  - Only one code should be paid
- CMS acknowledges that there may be extenuating circumstances that would support both codes of the pair being reported
- Purpose – to prevent unbundling, overcoding, and overpayment to providers

NCCI Procedure-to-Procedure (PTP) Edits

- *"Providers/suppliers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare "IOM" instructions."*
- *"Providers/suppliers must report services correctly. This manual discusses general coding principles in Chapter I, and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that providers/suppliers must avoid."*
- *"Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Providers/suppliers must not unbundle the services described by a HCPCS/CPT code."*
  - *NCCI Manual,* Chapter 1

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NCCI Procedure-to-Procedure (PTP) Edits

- CMS states, "*The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers/suppliers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination."*

- *"Outpatient hospitals and other providers/suppliers must code correctly even in the absence of NCCI or OCE edits."* (used in the context of new codes that are established and have not yet been integrated into the I/OCE)

  - Introduction to *NCCI Manual*

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NCCI Procedure-to-Procedure (PTP) Edits

- There are two types of PTP edits:
  - Column 1/Column 2
  - Mutually exclusive
  - The Integrated Outpatient Code Editor (I/OCE) claims adjudication process generates payment for the Column 1 code, and line-item rejects the Column 2 code
    - For Column 1/Column 2 codes, Column 1 code reimburses at a higher rate
    - For mutually exclusive codes, Column 1 code has lower reimbursement in many circumstances
  - For scenarios that CMS describes as "extenuating circumstances," when both codes are appropriate and allowed, the presence of an NCCI modifier will be considered by the I/OCE for reimbursement.

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NCCI Procedure-to-Procedure (PTP) Edits

- Mutually exclusive edit example

Col 1	Col 2		PTP Edit Rationale	Col 1 Definition	Natl Payment	Col 2 Definition	Natl Payment
70450	70480	1	Mutually exclusive procedures	CT head/brain w/o	$ 106.88	CT orbit w/o contrast	$ 106.88
70450	70481	1	Mutually exclusive procedures	CT head brain w/o	$ 106.88	CT orbit w contrast	$ 180.34
70450	70482	1	Mutually exclusive procedures	CT head/brain w/o	$ 106.88	CT orbit wo/w contrast	$ 180.34

- Only one code should be reported. Consider the code that provides the higher reimbursement to cover the additional costs of the additional views (both ordered, performed, and documented).

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Use of Modifiers for PTP Edits

- If the provider believes that extenuating circumstances are present (in cases where Medicare permits), a modifier may be used to indicate that fact.
  - The modifier may be appended to either the Column1 or the Column 2 code.
  - The specific extenuating circumstances must be documented in the medical record!

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Use of Modifiers for PTP Edits

- Extenuating circumstances allowed by CMS
  - Indicated by the modifier column in the PTP files
  - "1" in the modifier column indicates "yes"
  - "0" in the modifier column indicates "no"
  - "9" in the modifier column indicates the concept is not applicable (e.g., one or both codes no longer exist)

Column 1	Column 2	Effective date	Deletion Date	Modifier	PTP Edit Rationale
50020	69990	20000605	*	0	Misuse of column two code with column one code
63047	76000	20090701	*	1	Standards of medical / surgical practice
78586	78587	19960101	19960101	9	Mutually exclusive procedures
50081	52325	20140101	*	1	HCPCS/CPT procedure code definition
50360	50234	20031001	*	0	HCPCS/CPT procedure code definition
50010	44950	20020401	*	0	CPT Manual or CMS manual coding instructions
50010	99495	20201001	*	1	CPT Manual or CMS manual coding instructions
50010	60545	19970101	*	1	CPT "separate procedure" definition
50020	49000	20000605	*	0	CPT "separate procedure" definition

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Use of Modifiers for PTP Edits

- Examples:
  - Column 1/Column 2 codes: CPT 63047 (laminectomy, facetectomy & foraminotomy; lumbar) and CPT 76000 (fluoroscopy initial hour)
    - Modifier allowed (1) as there could be separate sites involved
  - NCCI Narrative Instructions
    - *"Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and shall not be reported separately.* (Chapter 9)
    - *"Fluoroscopy reported as CPT code 76000 shall not be reported with spinal procedures unless there is a specific 'CPT Manual' instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure."* (Chapter 8)

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Use of Modifiers for PTP Edits

- Examples:
  - Mutually exclusive codes: CPT 33206 (insertion or replacement of pacemaker with leads) and CPT 33222 (relocation of skin pocket for pacemaker)
    - Modifier not allowed (0)
    - The only reason for creating a skin pocket is for the insertion of the pacemaker and is an integral part of procedure 33206.

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Selection of Modifiers for PTP Edits

- First line modifiers include:
  - Anatomical modifiers (-RT, -LT, -F1–FA, -T1–TA)
  - Cardiac cath modifiers (-RC, -LC, -LD, -RI)
  - Global surgery modifiers for professional billing (-24, -25, -57, -58, -78, -79)
  - Should be considered first to see if they provide appropriate specificity to resolve the edit
    - Many times, just appending the modifier for anatomical specificity will resolve the edit and no further modifiers are necessary

Selection of Modifiers for PTP Edits

- Modifiers of "last resort": modifier -59, -X{EPSU}
  - Consider if no other modifier is applicable to the specific scenario
  - Modifier -59 is commonly used to override PTP edits
    - MLN Fact Sheet "Proper Use of Modifiers 59 & -X{EPSU}"
    - *https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf*
    - The fact sheet describes:
      - Definition of modifiers 59, XE, XP, XS, and XU
      - Appropriate and inappropriate use of these modifiers
      - Examples of appropriate and inappropriate use

Selection of Modifiers for PTP Edits

- Modifier -59 – Distinct procedural service
  - *"Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support 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. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."*
  - AMA definition, CPT manual

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Selection of Modifiers for PTP Edits

- CMS determined modifier -59 definition to be too broad; claims data didn't reflect the specific reason. Created the -X{EPSU} modifiers:
  - -XE: Separate encounter
  - -XP: Separate practitioner
  - -XS: Separate structure
  - -XU: Unusual non-overlapping service
- Use the -X{EPSU} modifiers before modifier -59 for Medicare claims.
- Review individual payer policy as some are accepting the X{EPSU} modifiers.

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Rate Setting Considering NCCI/MUE Edits

- **CMS *Provider Reimbursement Manual* Part 1, Chapter 22, Section 2202.4 Charges—**Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals*)
- Consider applying correct coding PTP edits to all patient accounts regardless of payer/insurance.

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NCCI Real-Life Examples

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Determine Whether a Modifier Should Be Used

- Questions to ask:
  - Are the correct codes reported based on the documentation?
  - Are the procedures related or connected?
  - Was one service provided in support of the other service?
  - Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)?
  - Can you support the "separateness," "unrelatedness," and/or "uniqueness" of each procedure?
  - Remember, you are considering the overall service and not the department(s) involved in the charging/coding.

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Emergency Endotracheal Intubation and Chest X-Ray

- The combination of CPT 31500 (emergency endotracheal intubation) and the codes for CXRs trigger a PTP edit.

Column 1	Column 2	Effective date	Deletion date	Modifier	PTP Edit Rationale
31500	71045	20180101	*	1	Misuse of column two code with column one code
31500	71046	20180101	*	1	Misuse of column two code with column one code
31500	71047	20180101	*	1	Misuse of column two code with column one code

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Emergency Endotracheal Intubation and Chest X-Ray

- A patient presents to the radiology department for a PA/Lat CXR ordered by his physician. The CXR is completed, and the patient leaves the radiology department. On his way out of the hospital, the patient complains of chest pain and shortness of breath. He is rushed to the ED where he experiences a respiratory arrest. He is intubated in the ED, and a portable 1-view CXR is performed to verify placement of the ET tube.
- The codes on the claim are:
  - CPT 31500 – emergency intubation
  - CPT 71045 – 1-view CXR
  - CPT 71046 – 2-view CXR
  - Would you add a modifier to the codes for the CXR?

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Emergency Endotracheal Intubation and Chest X-Ray

- For the **2-view CXR and the intubation:**
  - Are the correct codes reported based on the documentation? Yes
  - Are the procedures related or connected? No
  - Was one service provided in support of the other service? No
  - Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? Yes
  - Can you support the "separateness," "unrelatedness," and/or "uniqueness" of each procedure? Yes
- Modifier would be appropriate

- For the **1-view CXR and the intubation:**
  - Are the correct codes reported based on the documentation? Yes
  - Are the procedures related or connected? Yes
  - Was one service provided in support of the other service? Yes
  - Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? No
  - Can you support the "separateness," "unrelatedness," and/or "uniqueness" of each procedure? No
- Modifier would not be appropriate

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Emergency Endotracheal Intubation and Drug Administration Services – Example 1

- Patient presents to ED in respiratory distress and requires emergency intubation (CPT 31500). Physician ordered and patient received succinylcholine and etomidate IVP (CPT codes 96374, 96375) along with a hydration bolus (CPT 96361).

Column 1	Column 2	Modifier Indicator	PTP edit rationale
31500	96360	1	Standards of medical / surgical practice
31500	96361	1	Misuse of column two code with column one code
31500	96365	1	Standards of medical / surgical practice
31500	96366	1	Misuse of column two code with column one code
31500	96367	1	Misuse of column two code with column one code
31500	96368	1	Misuse of column two code with column one code
31500	96372	1	Standards of medical / surgical practice
31500	96374	1	Standards of medical / surgical practice
31500	96375	1	Standards of medical / surgical practice
31500	96376	1	Standards of medical / surgical practice

Emergency Endotracheal Intubation and Drug Administration Services

- Are the correct codes reported based on the documentation? Yes
- Are the procedures related or connected? Yes
- Was one service provided in support of the other service? Yes
- Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? No
- Can you support the “separateness,” “unrelatedness,” and/or “uniqueness” of each procedure? No

- A modifier is not appropriate in this scenario.

Emergency Endotracheal Intubation and Drug Administration Services – Example 2

- Patient is receiving chemotherapy treatment for lung cancer. After the infusion is complete and she is getting ready to leave, she complains of having difficulty breathing. The physician is called and responds to examine the patient. When the physician arrives, the patient is in respiratory distress, and the physician decides to emergently intubate the patient.
  - Codes on the claim:
    - 96413, 96415 x2 for the chemo infusion
    - 96367, 96375 for premedication administered for chemotherapy
    - 31500 for the intubation
    - 96375 x2 for IV push of etomidate and succinylcholine
    - 96361 for hydration

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Emergency Endotracheal Intubation and Drug Administration Services

- Are the correct codes reported based on the documentation? Yes
- Are the procedures related or connected? No
- Was one service provided in support of the other service? No
- Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? Yes
- Can you support the “separateness,” “unrelatedness,” and/or “uniqueness” of each procedure? Yes

- A modifier is appropriate in this scenario.

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Emergency Endotracheal Intubation and Drug Administration Services – Example Comparison

- For the **chemotherapy services and the intubation:**
  - Are the correct codes reported based on the documentation? Yes
  - Are the procedures related or connected? No
  - Was one service provided in support of the other service? No
  - Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? Yes
  - Can you support the "separateness," "unrelatedness," and/or "uniqueness" of each procedure? Yes
- Modifier would be appropriate

- For the **IVP of etomidate and succinylcholine and the intubation:**
  - Are the correct codes reported based on the documentation? Yes
  - Are the procedures related or connected? Yes
  - Was one service provided in support of the other service? Yes
  - Does the documentation support that the services were distinct (e.g., separate procedure, separate anatomical site)? No
  - Can you support the "separateness," "unrelatedness," and/or "uniqueness" of each procedure? No
- Modifier would not be appropriate

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CT/CTA or MRI/MRA of Same Anatomical Area

- Patient presents to radiology department for a CT and CTA of the head due to prolonged severe headaches. Practitioner has ordered both procedures to be performed.
  - CPT 70470 – *Computed tomography, head or brain; without contrast material*
  - CPT 70496 – *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing*
- The procedures are performed at the same time (single technical study) and the patient leaves.
- Radiology enters a charge for the CT head and a CTA of the head. Two radiology reports are generated.

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CT/CTA or MRI/MRA of Same Anatomical Area

- *"Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the CT and one for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon."*

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CT/CTA or MRI/MRA of Same Anatomical Area

- *"Similarly magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon."*
  - *NCCI Manual,* Chapter 9

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CT/CTA of Same Anatomical Area

- PTP edits
- Column 1 = CTA; Column 2 = CT (brain/head)

Column 1	Column 2	Effective date	Deletion date	Modifier	PTP Edit Rationale
70496	70450	20100101	*	1	Misuse of column two code with column one code
70496	70460	20100101	*	1	Misuse of column two code with column one code
70496	70470	20100101	*	1	Misuse of column two code with column one code

- Consideration – composite payment under the OPPS
  - Adding an NCCI modifier (-59/-X{EPSU}) triggers composite APC reimbursement, which is a higher reimbursement than the individual exam
  - APC 8006 (CT/CTA with contrast) = $434.16
  - CPT codes 70496, 70460, 70470 = $180.34
  - CPT 70450 = $106.88

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MRI/MRA of Same Anatomical Area

- PTP edits
- Column 1 = MRA w/wo; Column 2 = MRI

Column 1	Column 2	Effective date	Deletion Date	Modifier	PTP Edit Rationale
70546	70551	20100101		1	Misuse of column two code with column one code
70546	70552	20100101		1	Misuse of column two code with column one code

- Consideration – composite payment under the OPPS
  - Adding an NCCI modifier (-59/-X{EPSU}) triggers composite APC reimbursement, which is a higher reimbursement than the individual exam
  - APC 8007 (MRI/MRA with contrast) = $845.72
  - CPT codes 70546, 70552 = $368.43
  - CPT 70551 = $233.52

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Medically Unlikely Edits (MUEs)

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Medically Unlikely Edits

- MUEs place limitations on the units of service that can be reported
  - Defined by CMS as the "*maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service*."
    - *NCCI Manual,* Chapter 1
- Purpose – to lower the Medicare Fee-For-Service Paid Claims Error Rate
- CMS has published some MUE values but considers other to be proprietary

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Medically Unlikely Edits

- MUEs are applied during claims processing in one of two ways
  - By claim line – each claim line is compared to the established MUE for the service. If the units on the individual claim line exceed the MUE, then that line item is denied.
  - By date of service (DOS) – All units for the code are summed and then the sum is compared to the established MUE. If the total units exceed the MUE, all units for that date of service are denied.
- MUE file contains a column listing the MUE Adjudication Indicator (MAI) indicating how an MUE will be applied
- Appeals are filed with the MAC

Medically Unlikely Edits

- MUEs applied by claim line
  - MAI of "1"
  - The applicable MUE is applied to the individual line
  - Many MUEs were originally applied to the claim line but have changed to DOS edits over time.
  - For codes subject to MUE limitations and adjudicated at the claim line level, hospitals should report medically appropriate units in excess of limit on separate lines, with an appropriate modifier, so no single line exceeds limitation. (NCCI Manual, Chapter 1)

Medically Unlikely Edits

- MUEs applied by claim line (continued)
  - *"If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, (i.e., MAI equal to "1") appropriate use of CPT modifiers (i.e., 59 or -X{EPSU}, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes." NCCI Manual,* Chapter 1
  - Documentation should support the medical appropriateness
  - MUEs with MAI of "1" that are denied for units exceeding the MUE can generally be appealed.

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Medically Unlikely Edits

- MUEs applied by date of service
  - Transmittal **R1421OTN -** Revised Modification to the Medically Unlikely Edit (MUE) Program – August 2014
  - All lines on the claim containing the same HCPCS code and same DOS will be summed and compared to the MUE value
  - If the total units exceed the MUE, all claim lines with that code for that date of service will be denied, regardless of modifier.
    - *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R1421OTN*

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Medically Unlikely Edits

- MUEs applied by date of service
- Assigned MAI of "2" or "3"
  - MAI "2" – edit is based on policy plus regulatory and sub-regulatory guidance
    - Defined by CMS as "absolute date of service edits" based on policy
    - Units of service exceeding the MUE value are considered "impossible."
      - » E.g., CPT 94002 – Ventilation assist and management, initial day. MUE is 1 and there would be no more than 1 initial day
    - MACs are bound to the MUE for both initial decisions and redeterminations
    - Higher-level appeals adjudicators may not be bound by the MUE, but should give deference to them

Medically Unlikely Edits

- MUEs applied by date of service (cont'd)
  - MAI "3" - edit is based on clinical information (e.g., prescribing information, nature of the service, etc.)
    - Defined by CMS as "per day edits based on clinical benchmarks."
    - Highly unlikely or impossible that the units would exceed the MUE
    - Providers may appeal denials based on medical necessity for an individual patient.
    - MACs may review a claim, reopen a claim, and/or bypass the MUE based on documentation supporting the medical necessity

Medically Unlikely Edits

- If the code descriptor does not specify a unit of service, the MUE value for a code may be set to "1" as CMS considers the default unit of service (UOS) to be "per day"

- *"Although clinical judgment considerations and determinations based on input from numerous physicians and certified coders are sometimes initially utilized to establish some MUE values, these values are subsequently validated or changed based on submitted and/or paid claims data." NCCI Manual,* Chapter 1
- *"Submitted and paid claims data (100%) from a six-month period is utilized to ascertain the distribution pattern of UOS typically reported for a given HCPCS/CPT code." NCCI Manual,* Chapter 1

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Medically Unlikely Edits

- HCPCS J-codes and drug related C and Q-code MUEs
  - Determined based on prescribing information and 100% of claims data for a six-month period.
  - Prescribing information determines the highest total daily dose for the drug.
  - This dose and its corresponding UOS are evaluated against paid and submitted claims data.
    - "*For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter 2 cases, the daily dose calculation was evaluated against claims data."*
    - *Published off-label use of a drug is considered for the maximum daily dose calculation.*

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Medically Unlikely Edits

- HCPCS J-codes and drug related C and Q-code MUEs
  - *"If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg was evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg was evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters was evaluated against claims data."*
- MUE values set to zero
  - The drug is no longer manufactured; the compounded drug is not FDA-approved; some drugs should be billed to the DME MAC, etc.
  - Non-drug codes set to zero – inpatient-only procedure codes, noncovered services, bundled services, packaged services.

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Medically Unlikely Edits

- *"Most MUE values are set so that a provider/supplier would only very occasionally have a claim line denied. If a provider/supplier encounters a code with frequent denials due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the following:*

  (1) Is the HCPCS/CPT code being used correctly?

  (2) Is the unit of service being counted correctly?

  (3) Are all reported services medically reasonable and necessary? and

  (4) Why does the provider's or supplier's practice differ from national patterns?

  A provider or supplier may choose to discuss these questions with the local Medicare contractor or a national healthcare organization whose members frequently perform the procedure."

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Medically Unlikely Edits

- Many make sense
- MUE = 1
  - 58260–58270 – Vaginal hysterectomy procedures
  - 64611 – *Chemodenervation of parotid and submandibular salivary glands, bilateral*
  - U0005 – Covid-19 high throughput add-on code (gsq tpixihs{ mxlmr$k{ s$gepirhev$he}w$jvsq $ hexisjwtigmq ir$gspmigxsr-
- MUE = 2
  - 27603 – *Incision and drainage, leg or ankle; deep abscess or hematoma*
  - 73000 – *Radiologic examination; clavicle, complete*

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Medically Unlikely Edits

- Published MUEs breakdown:
  - Facilities
    - Claim line adjudicated MUEs (MAI = 1) for January 2023 = 40
    - Date of service (DOS) adjudicated MUEs (MAI 2, 3) for January 2023 = 14,330
  - Professional
    - Claim line adjudicated MUEs (MAI = 1) for January 2023 = 39
    - DOS adjudicated MUEs (MAI 2, 3) for January 2023 = 14,375
- MUEs apply to Medicare claims only, unless a non-Medicare payer has specifically adopted the MUEs
  - *https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-medically-unlikely-edits*

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MUE – Venipuncture

- Venipuncture (CPT 36415)

HCPCS/ CPT Code	OP Hosp SVC MUE Values	MUE Adjudication Indicator	MUE Rationale
36415	2	3 Date of Service Edit: Clinical	CMS Policy

  - CPT code has no unit of service defined. *"Collection of venous blood by venipuncture."*
  - *"CPT code 36415 describes collection of venous blood by venipuncture. Each unit of service of this code includes all collections of venous blood by venipuncture during a single episode of care regardless of the number of times venipuncture is performed to collect venous blood specimens. Two or more collections of venous blood by venipuncture during the same episode of care are not reportable as additional UOS. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility." NCCI Manual,* Chapter 5

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MUE – Venipuncture

- Caution – date of service edit
  - No claim edit triggered unless units are in excess of 2
  - If only one episode of care, can only bill unit of 1
  - Documentation would have to support two separate episodes of care based on CMS' definition to report 2 units.
  - Easy claims data mining and request for supporting documentation
  - Consider observation patients and outpatients staying past midnight
  - Instructions for charging multiple venipunctures and reporting one unit seem to conflict. How do you satisfy both requirements?
    - CMS/NCCI definition states the one unit includes all blood collections provided during an episode of care.

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MUE – Nebulizer Treatments

- Nebulizer treatments (CPT 94640)
  - Facility MUE

HCPCS/ CPT Code	OP Hosp SVC MUE Values	MUE Adjudication Indicator	MUE Rationale
94640	1	3 Date of Service Edit: Clinical	Clinical: Data

- CPT code has no unit of service defined. “Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device.”

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MUE – Nebulizer Treatments

- *“CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction...(IPPB) device) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) shall not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.” – NCCI Manual,* Chapter 11

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MUE – Nebulizer Treatments

- *"An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care. If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640." – NCCI Manual,* Chapter 11

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MUE – Nebulizer Treatments

- Caution – date of service edit
  - No claim edit triggered unless units are in excess of 2 if a modifier is appended
  - If only one episode of care, can only bill unit of 1
  - Documentation would have to support two separate episodes of care based on CMS' definition to report more than 1 unit.
  - Easy claims data mining and request for supporting documentation
  - Consider observation patients and OP staying over midnight
  - Instructions for charging multiple treatments and reporting one unit seem to conflict. How do you satisfy both requirements?
  - *"CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered."*

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National Correct Coding Initiative

Add-On Code Edits

Add-On Code Edits

- Add-on codes
  - Always performed in conjunction with a primary service
  - Eligible for payment only when provided with appropriate primary service
    - Divided into Type I, 2, or 3
    - Having “ZZZ” global surgery period on MPFS, or
    - Being designated with a “+” symbol in CPT
  - CMS publishes a list prior to January of each year; updates quarterly and are retroactive to January of that year
    - https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-add-code-edits
  - I/OCE edit 84 – reported without primary code
  - Edits established April 2013

Add-On Code Edits

- Type I
  - Limited number of specifically defined primary codes
  - Defined by CPT, HCPCS manuals, and/or CMS policy
- Type 2
  - No list of acceptable primary codes defined by CPT, HCPCS manual, and/or CMS policy
  - MACs must develop
- Type 3
  - Some, but not all primary codes have been identified by CPT, HCPCS manuals, and/or CMS policy
  - MACs must accept the identified primary codes and may add additional primary codes to the list

Requesting Review/Change to an NCCI Edit

Requesting Review/Change to an NCCI Edit

- What if the edit is unreasonable?
  - There is a process for providers to dispute or request a change to an edit.
  - "*The NCCI program is maintained for the CMS by a contractor. If the user of this manual has concerns regarding the content of the edits or this manual, the user may send an inquiry in writing to the CMS NCCI PTP/MUE email address or address identified on the CMS NCCI webpage.*"
    - *NCCI Manual,* Introduction chapter – last page
  - CMS website contains the mailing address of the NCCI contractor: *https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare*

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Requesting Review/Change to an NCCI Edit

- *"A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of a PTP edit, an MUE value or an AOC edit for a HCPCS/CPT code by submitting a written request to: NCCIPTPMUE@cms.hhs.gov. The written request should include a rationale for reconsideration, as well as a suggestion. Any submissions made to the NCCI contractor that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically discarded, regardless of the content, in accordance with federal privacy rules with which the NCCI Contractor must comply."*
  - *NCCI Manual*, Introduction

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Mitigating Edits Prior To The Billing Process

Root Cause Analysis

- Root cause analysis – process of getting to the root of the situation
  - Review prebill system processes/workflows to determine where the situation occurs
  - Determine the underlying issue(s) or event(s) and design a “treatment plan” to mitigate the situation at that point in the process
- Process review
  - Is the current process/workflow working? If not, why not?
  - Are departments involved? How/what is the communication process? (HIM and PFS; departments and HIM; PFS and departments?)
  - Do you have a balance between discharged not final billed (DNFB) and keeping the appropriate reimbursement by ensuring that a correctly coded claim is submitted?

Pre-Bill Edits

- Best practice: trigger PTP and add-on code edits at coding and again in PFS prior to billing
  - Ensure these edits are applied to all patient accounts regardless of insurance
- Review the edit triggers and determine which edits are highest volume
  - Regular meetings with revenue integrity team, HIM, department representatives to review edits and strategies for resolution early in the process
- Ensure correct modifier use
  - Determine who will have responsibility to review the documentation. Modifiers are applied based on the entire claim and not based on the department who provided the service or how many orders had to be placed.
  - If a modifier is appropriate, who will have the responsibility to add it?
  - Are modifiers -59 and/or -X{EPSU} coded on the chargemaster? Revisit this process in terms of needing to review documentation for appropriateness of the modifier.
    - Consider a process for reviewing each scenario to ensure modifier is appropriate.

Pre-Bill Edits

- Internal edits to mimic NCCI, MUE, and add-on code edits
  - Custom edits for specific payers – Where are the opportunities? Find the balance between accurate reimbursement and resolution of coding situations that trigger edits. What brings the most value and improves the operational flow?
  - Who builds the edits in the system? Encoder, clearinghouse, billing system vendor or internal staff (e.g., IT, PFT, etc.)
    - Where is the decision made to institute a new edit? The vendor may have researched on the "how and what" but is the volume significant enough to implement the edit? Balance the situation with the amount of work that will need to be done internally.
  - Do the edits reflect NCCI guidance?
  - Are edits current? What is the lag time between publication of edits and implementation?
    - Establish a process and responsible party/parties to review quarterly/annually to ensure working as intended

Pre-Bill Edits

- Best practice is to trigger MUE edits prior to submitting Medicare claims
  - As you evaluate MUEs for Medicare, consider if there is an issue of incorrect units being charged.
  - For pharmacy items, are the conversion mechanisms (e.g., multiplier tables) working correctly to translate the dose administered to the units described by the HCPCS code?
  - For packaged services, are HCPCS required?
    - For example, for MUEs related to medications for which payment is packaged, consider billing under revenue code 0250 and no HCPCS code.

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Pre-Bill Edits

- Review situations and create instructions for different scenarios.
  - When edits involve services provided in the same department (for example, radiology services):
    - Who reviews the codes and corrects them?
    - How are they corrected – credited/modified/improved documentation?
    - Plan to prevent perpetuating the same scenario/triggering the same edit.
  - When edits involve services provided in multiple departments (for example, radiology and surgery):
    - Who reviews the codes and corrects them?
    - How are they corrected – credited/modified/improved documentation?
    - Plan to prevent perpetuating the same scenario/triggering the same edit.

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Resolving Edits

- Check that coding and clearinghouse are using same source of edits
  - Ensure that all edits are current
  - If account is correct internally, does it pass DDE with Medicare?
- What happens when accounts continue to edit at billing?
  - Edits should be designed to solve a problem and not impede workflow – the goal is to prevent rejected/denied claims and rework. Is the edit working correctly and generating the intended outcome?
  - Consider weekly team meetings to jointly review accounts and edits being triggered.
- Questions to ask:
  - Are edits being applied consistently by HIM/PFS?
  - If different, what is the correct edit?
  - What is the source of truth?

Appealing Edits

- Once a service is confirmed to be medically necessary, properly coded, modified, billed, and rejected (line item or entire claim), consider appealing
- MAC is likely to uphold denial
- Second-level appeal to Qualified Independent Contractor is not bound by NCCI
  - NCCI is sub-regulatory guidance and does not carry the weight of law as with statutes and regulations
- Consider writing to NCCI contractor
- Consider raising questions on CMS Hospital Open Door Forums

How an Edit Is Resolved Can Affect Rate Setting

- If hospital providers just adjust the charges off the claim at time of billing as a contractual:
  - The cost-to-charge ratios Medicare uses in rate setting from hospitals include the expense and revenue
  - But the claims that CMS uses for rates only include the billed charges
  - Therefore, the payment rates decline
- Also, if hospitals merely adjust medically necessary units to the MUE levels and do not appeal/complain, future edits will be more stringent as evidenced with the MUE for 94640

National Correct Coding Manual Updates For CY 2023

NCCI Manual Updates - 2023

- Updates to each chapter's initial page:
  - Medicare National Correct Coding Initiative Policy Manual
  - Fee schedules, relative value units, conversion factors, and/or related components aren't assigned by the AMA, aren't part of CPT, and the AMA isn't recommending their use. The AMA doesn't directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.
  - CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.
  - Additional updates of "provider" to "provider/supplier"
  - Changed "provider and supplier" and "provider or supplier" to "provider/supplier"
  - The Centers for Medicare & Medicaid is updated to be The Centers for Medicare & Medicaid Services.

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NCCI Manual Updates - 2023

- Overall
  - Additional updates of "provider" to "provider/supplier"
  - Changed "provider and supplier" and "provider or supplier" to "provider/supplier"
  - Added reference to For more information regarding biopsies, see Chapter I, Introduction, Section A.
  - Editorial language updates
    - For example, "if a PTP edit" changed to "When an NCCI PTP edit"
  - Updated referenced CPT code definitions to match the actual CPT definition published by AMA. For example, Diagnostic bone marrow, aspiration(s)
  - Updated affected CPT code ranges based on AMA updates.
  - Added notations of CPT codes deleted January 1, 2022, and January 1, 2023
- Introduction
  - Added information regarding what is contained on the NCCI webpages.

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NCCI Manual Updates - 2023

- Chapter 1 – General Correct Coding Policies
  - Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. For more information concerning MUEs, see Section V of this chapter.
  - Changed Type I, Type II, and Type III to Type 1, Type 2, and Type 3 in regard to the Add-on code edits.
  - CMS will update the complete list of AOC edits 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 a complete list of AOC edits, if necessary, on April 1, July 1, and October 1 of each year. If no changes occur in the AOC edits, no quarterly update will be posted.

NCCI Manual Updates - 2023

- Chapter 2 – Anesthesia Services
  - Added the full definition of abbreviations and placed the abbreviation in parentheses, such as Electroencephalography (EEG), Central Nervous System (CNS), Brainstem-evoked Response (BSER).
- Chapter 3 – Integumentary System
  - Clarified 11400 – 11471 (Excision of benign lesions) and 11600 – 11646 (Excision of malignant lesions)
- Chapter 4 – Musculoskeletal System
  - CPT codes 22600-22614 describe arthrodesis by posterior or posterolateral technique and lateral transverse technique when performed.

NCCI Manual Updates - 2023

- Chapter 5 – Respiratory, Cardiovascular, Hemic and Lymphatic Systems
  - Editorial changes only
- Chapter 6 – Digestive System
  - Includes updates to guidance based on the AMA changes to hernia surgery codes for 2023.
    - CPT code 49568 was an AOC describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. (CPT code 49568 was deleted January 1, 2023.)
- Chapter 7 – Urinary, Male/Female Genital, Maternity Care and Delivery Systems
  - Editorial changes only

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NCCI Manual Updates - 2023

- Chapter 8 – Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems
  - CPT codes 62321, 62323, 62325, and 62327 describe injections of diagnostic or therapeutic substance(s) into the epidural or subarachnoid spaces at different spinal levels with fluoroscopic or CT guidance. Imaging guidance such as CPT code 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)) or 77012 (Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation) is included in these procedures and should not be reported separately with these codes.

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NCCI Manual Updates - 2023

- Chapter 9 – Radiology Services
  - E&M services (i.e., 99211-99213) may be reported with CPT code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day) with modifier 25 for the purpose of reporting physician services for certain aspects of radiation therapy planning. Modifier -59 is not appropriate to use with weekly radiation therapy management codes (77427) or with evaluation and management services codes (99202 - 99499).
  - Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77081, 76977, or G0130. Although it may be medically reasonable and necessary to perform an axial and a peripheral bone density study on the same date of service, NCCI PTP edits prevent the reporting of more than one axial bone density study or more than one peripheral site bone density study on the same date of service.

NCCI Manual Updates - 2023

- Chapter 10 – Pathology/Laboratory Services
  - Definitive drug testing may be reported with HCPCS codes G0480-G0483 and G0659. These codes differ based on the number of drug classes including metabolites tested. Only one code from this group of codes may be reported per date of service.
  - CPT codes 81445, 81450, and 81455 describe targeted genomic sequence, DNA analysis or combined DNA and RNA analysis. 81445 applies to solid organ neoplasm type (5-50 genes) and 81450 applies to hematolymphoid neoplasm type (5-50 genes), while 81455 applies to the number of genes analyzed for either a solid or hematolymphoid neoplasm (51 or greater genes). Providers/suppliers may not report 81455 with either 81445 or 81450. CPT codes 81449, 81451, and 81456 describe targeted genomic sequence RNA analysis using a separate method.

NCCI Manual Updates - 2023

- Chapter 11 – Medicine, Evaluation and Management Services
  - Updates references to CPT codes for E/M services based on changes by AMA effective January 1, 2023.
  - The prolonged service with or without direct face-to-face patient contact E&M codes (CPT/HCPCS codes 99417, 99418, G2212, G0316) may be reported in conjunction with some E&M codes. (CPT Codes 99354-99357 were deleted January 1, 2023.)
  - Since critical care (CPT codes 99291-99292) and prolonged E&M services (CPT/HCPCS codes 99417, 99418, G2212, G0316) are reported based on time, providers/suppliers shall not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged provider E&M service time. (CPT Codes 99354-99357 were deleted January 1, 2023.)
  - The code descriptors for CPT codes 90846 (Family psychotherapy (without the patient present), 50 minutes) and 90847 (Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes) describe 50 minutes of family psychotherapy.

NCCI Manual Updates - 2023

- Chapter 12 – Supplemental Services – HCPCS Level II codes
  - HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an E&M code (e.g., CPT/HCPCS codes 99202-99499, G0463, G0466-G0470, G0438, G0439).
- Chapter 13 – Category III CPT Codes
  - Editorial changes only

Questions & Answers

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http://events.hcpro.com/materialspub.cgi?YHHA011823A

We kindly request that this link be forwarded to everyone in your group who attended the program.

This concludes today's program.

Be sure to register for our upcoming program:

Chargemaster Maintenance and Charge Capture Strategies for Revenue Integrity

February 16, 2023 at 1:00 p.m. ET

https://hcmarketplace.com/chargemaster-maintenance

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