CHAPTER 6 - NCCI EDITS AND MODIFIERS

Coding edits apply when a provider reports more than one claim for a patient. If there is one claim for one patient on one day, there is no problem, and no edit is needed. The potential problem arises when there are multiple claims for a single day. Payers want to ensure they are not paying for duplicate or unnecessary services and use edits to deny these claims. Most of the modifiers were developed to address this problem and inform payers that additional CPT codes were actually performed and not billed in error.

Examples: you saw a 2-year-old for a well-child check and billed 99492, but the patient also had AOM and you prescribed antibiotics and arranged follow-up. You already billed 99492 for that day. If you also bill 99213 for an AOM sick visit, the payer may think it was reported by mistake and deny it. Actually, this action may be performed by software, and one of your 2 CPT codes may be denied. This is called coding edits. When reported together, some codes are mutually exclusive. For some code pairs, there is no way to override the edit. Which means some codes can never be reported with others. For some other code pairs, coding edits can be overridden by a modifier. Back to our example, if you add modifier 25 to the second CPT code, 99213, it will tell the payer that this service is a significant, separately identifiable E/M service, and both of your claims will be accepted.

Many different modifiers exist to override or bypass these coding edits and tell payers that these are not unnecessary, duplicate, or accidental services, but are actually needed for patient care. Most physicians have minimal knowledge of modifiers. Typically, coders take care of modifiers.

NCCI (National Correct Coding Initiative) edits, developed by CMS, set the standard for the entire healthcare industry. There are 2 types of edits. The first type, which was already explained above, is procedure-to-procedure edits. You can Google “NCCI procedure to procedure” or go to its website

https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits . You need to download an Excel file to look up code pairs on this website, or go to https://www.cgsmedicare.com/medicare_dynamic/j15/ptpb/ptp/ptp.aspx . On the second website, you only need to enter the code you want to know about. Then the software will list all the mutually exclusive codes for that given code. If a code is not in the list (no pairing), then they may be both reportable, although there may be other rules about the code pair that are not covered in NCCI edits. Even if not in the list, when you report 2 different E/M services on the same day, it is still recommended to use modifier 25.

Example: you saw a well newborn and billed 99460. Baby got sick the same day, and you admitted the baby to the floor. The question is: can you report both 99460 normal newborn care and 99223 admissions to inpatient care on the same day? Well, let’s figure it out. Let’s go to the NCCI edit website and enter 99460 into the search box. The software will display a long list of CPT codes that may not be reportable with 99460. After each code pair, the system displays a 0 or a 1. If zero is displayed, it means there is no way to bypass this edit, and these 2 codes are never reported together. If 1 is displayed, then you can bypass the edit and report both codes with a modifier. To our luck, 99223 is not even on the list of 99460; this means you should be able to report both 99460 and 99223 on the same day without any problem or modifier. But this is where the system's complexity begins, because the NCCI edit is not the end of the story. The AAP coding book specifically states that the same physician cannot use normal newborn codes, such as 99460, with hospital codes, such as 99223, on the same day. The source of this

bundling is not clarified in the AAP book, but it is likely because both codes are considered initial care codes.

You had a 3-month-old patient with bronchiolitis that you billed 99233 in the morning. In the afternoon, the patient got worse and was intubated. Now you need to bill 99471. But can you report both 99233 and 99471 on the same day? If you look at the NCCI edit, you see that 99233 and 99471 are not paired, which means these 2 codes can be billed on the same day. Modifier 25 still needs to be attached to 99471 to indicate that it is a separate service from 99233.

In another example, let's say your hospitalist colleague in the same physician group admitted a patient with CPT code 99223 at 4 am. You rounded around at noon and billed 99233. Can these 2 codes be reported on the same patient on the same day? According to the code definitions, 99233 is not reportable because it is not a subsequent day yet. Because of this, if you use NCCI edit and look at the code pair 99223 - 99233, you will see that a zero number is displayed next to the pair, meaning these codes can never be reported together, and no modifier will bypass this block.

Another example: you performed 2 incision and drainage procedures, one on the left and one on the right leg. One was complex I&D, and the other was simple. CPT code for simple I&D is 10060, and CPT code for complex I&D is 10061. Per CPT, simple I&D is a component of complex I&D, so if you report them together, your claim may be denied. So let's ask NCCI edit. Let's go to the website and enter 10061 into the search box. You will see the code pair, 10061 and 10060, and the next box will display 1. This means that you can bypass this edit with a modifier. Appropriate modifier would be 59, which means distinct procedural service (a different site/organ system, separate incision or excision, separate lesion). So, in our example, we can report both I&D procedures by attaching modifier 59 to 10060, since we told the payer they are separate procedures.

Another type of NCCI edit is called a medical unlikely edit. This is simply a cap on the number of units of a procedure you can report on a given day. There is a long list of modifiers, but most are related to surgical procedures. Most pediatricians need to know only a few. Interested readers may find more information on modifiers in the CPT code book or the AAP Coding for Pediatrics book.

Modifier 25: significant, separately identifiable E/M service by the same provider on the same day of the procedure or service. It is probably the single most important modifier for most pediatricians. Any time you report more than one E/M service code for the same day, consider using modifier 25. For example, if you uncover that the patient's asthma is getting worse and start the patient on controller during a well-child check, then you should report both WCC code and sick code with modifier 25.

You saw a patient in the office in the morning for URI, which you billed 99212. If the same patient returns in the afternoon for a fractured arm, you can report this service using an appropriate office code, such as 99213, and modifier 25.

Modifier 22 is used for procedural services that take longer than usual, such as spending 45 minutes putting a couple of stitches in the wound of a combative 2-year-old. Given the difficulty of the procedure, modifier 22 may help increase RVUs and hence revenue.

Modifier 24 is used to report unrelated E/M service in the post-operative or procedure period and is mostly used by surgeons.

Modifier 26: professional component. It is used by radiologists and other physicians when reporting the findings of a test or imaging study. Like a cardiologist reporting an EKG or ECHO findings.

Modifier 59: distinct procedural service is used to bypass NCCI edits

Modifier 63: procedure performed on an infant less than 4kg. Given the difficulty of the procedure, modifier 63 may help increase RVUs and hence revenue.

Modifier 91: repeat clinical diagnostic test

Modifier 93: synchronous telemedicine service, audio only. May be used with regular office codes.

Modifier 95: synchronous telemedicine service, audio-video. May be used with regular office codes.