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Aimee Wilcox, CPMA, CCS-P, CST, MA, MT

On the topic:
How to Properly Unbundle Surgical Procedures
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How to Properly Unbundle Surgical Procedures

Aimee L Wilcox, CPMA, CCS-P, CST, MA, MT

- National Correct Coding Initiative
- CMS Editorial Panel
- Policy Manual
- Quarterly CCI edit updates
- Annual policy manual updates
- Part B services
- Procedure-to-Procedure (PTP) began in 1996
- Medically Unlikely Edits (MUEs) in 2007

Second set of NCCI edits within outpatient code editor (OCE) for OPPS & corresponding MUEs
Claims Processing

- PTP edits are automatic/built into MCR systems
- Denied services cannot be billed to Medicare beneficiaries
- ABNs cannot be utilized to seek payment for denied services due to CCI edits
- All possible edits are not listed
- Overpayments must be returned
- Audit findings must adhere to effective dates
- Policy manual contains additional information

Column 1 & 2 P2P Edits

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NCCI Validator Tools

CCI Policy Manual

National Correct Coding Initiative Policy Manual for Medicare Services
Revision Date: 1/1/2019
What circumstances would justify unbundling this code pair edit?

Different lesions
Different part of the body
Common NCCI Edit Mistakes

- Applying the unbundling modifier to the Column 1 code.
  - Although a number of modifier may be used to unbundle services (e.g., RT, LT), when modifier 59 or one of the X-(EPSU) modifiers are reported, they should only ever be appended to the Column 2 code (the code that would otherwise be denied).

- Lack of supporting documentation
  - The medical record should clearly identify the circumstances that qualify it for unbundling.

MLN Matters

How to Use the National Correct Coding Initiative (NCCI) Tools

"Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to an HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled."
Diagnostic vs Therapeutic

**WATCH for BUNDLING**
Diagnostic procedures may stand alone or may be bundled into a therapeutic procedure; even within the same session.

**Examples**
- Facet injections*
- Biopsies
- Endoscopy
- Laryngoscopy
- Interventional procedures
- Image guidance
- Pathology driven procedures
- Diagnostic endoscopic to surgical endoscopic to open procedure
- Diagnostic laparoscopic to surgical laparoscopic to open procedure

* Ablation of spinal nerves has a pre-surgery requirement of:
  - tried and failed conservative treatment
  - 2 initial facet injections (diagnostic) with 80% relief
  - strict utilization limitations

You must follow not only the NCCI edits, but also the LCD or NCD guidance.

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**General Rules**

- Shall not inconvenience beneficiaries nor increase risk to them by performing services on different dates to avoid MUE or NCCI PTP edits
- Endoscopic procedure fails and is converted to another surgical procedure the provider will report only the completed surgical procedure
- Diagnostic endoscopy is never separately reportable with another endoscopic procedure of the same organ (same pt/same encounter)
- Must follow the CPT/HCPCS code description with reporting based on units of service or time (not interchangeable)
- All aspects of the code description must be performed in order to report it or an appropriate modifier to identify reduced services is reported
- An excision and removal (-ectomy) includes the incision and opening (-otomy) of the organ. A HCPCS/CPT code for an –otomy procedure shall not be reported with an –ectomy code for the same organ
Unbundling Modifiers

E/M Modifiers
- 25
- 57

Operation unbundling
- 54 Surgical care only
- 55 Preoperative only
- 56 Postoperative only

Anatomical modifiers
- E1-E4 eyelids
- F1-FA hands/digits
- LT/RT
- T1-TA feet/digits

Separate/Distinct procedure
- Modifier 59

Medicare X (EPSU) modifiers
- XE Separate Encounter
- XP Separate Practitioner
- XS Separate Structure
- XU Unlisted, Non-overlapping service

Example 1

In 2015, a bariatric surgery practice performed many gastric restrictive procedures (43775) which when completed, was followed by an EGD performed by the assistant surgeon with a separate report. The indications for the EGD stated, “to check suture lines for leaks following laparoscopic sleeve gastrectomy”

The payer claimed there was an NCCI edit and the provider owed the money back, citing the 2016 NCCI Policy Manual guidelines.

The provider argued the EGD was valid as the report documented a full EGD was performed.
Audit

- Provider Defense
  - No NCCI edit exists between 43775 and 43235
  - In 2015 there was no policy manual guidance on these two services.
  - The payer’s auditor is citing 2016 rules for 2015 dates of service.
  - NonMedicare patient and private payer has no published policy stating they follow the CCI rules and no policy stating the CCI Policy Manual trumps the CCI edits when no edit exists.

Example 2

- In 2015, the surgeon performed several gastric restrictive procedures in which the patients also suffered from large paraesophageal hernias that were repaired during the same session. In some cases a simple figure-of-eight suture was all that was needed to make the repair and at other times significant dissection of the adhesions were required to free the hernia sac in order to pull it back into anatomical position and then multiple layers of sutures were required to hold it in place and repair the tear in the diaphragm.
- As an NCCI between the gastric restrictive procedure (43775) and the hernia repair (43281) was noted, the surgeon reported both codes and placed a modifier 59 on the 43281 so it would get paid.
- Two years later a payer audit resulted in a demand for repayment for the hernia repairs, citing the 2016 NCCI edit and unsupported unbundling by the provider.
DATE OF SERVICE: 12/01/2017
PATIENT NAME: Wouldn’t Ulike2Know

This 68-year old patient is here for repeat knee joint and trigger point injections. The last time she had the injections was in November, which provided significant relief.

PROCEDURES:
1. Bilateral knee joint injections. After alcohol prep on each knee, taking lateral approach, posterior to the patella, a 25-gauge, 3.5-inch needle was advanced into the knee joint. Five mL of 0.25% Marcaine with 20 mg of Kenalog was injected into each side for a total of two injections.

2. Trigger points were identified bilaterally in the supraspinatus muscles. A total of 10 mL of 0.25% Marcaine, 5 mL per side, with 40 mg of Kenalog total was used to inject the two trigger points. There were no complications.

IMPRESSION:
1. Osteoarthritis of the knees (M17.9).
2. Myofascial pain syndrome (M79.1).

PLAN: Return in about two months for repeat injections.

John Smack, MD
12/01/2017 09:10:56
(Electronic signature requirements met)

Do you think overriding the edit with modifier 25 would be supported by this note? Why?
Global Periods

Global Indicators

XXX  Global concept doesn’t apply
000  Zero days
010  Ten days (really 11)
090  Ninety days (really 92)
MMM  Maternity codes (OB package)
YYY  Unlisted codes (payer review)
ZZZ  Add-on (+) codes (see primary)

What’s Included in the Global Period?

• E/M service (pre & postop)
• Services (normal & necessary)
  • Incision
  • Suturing
  • Local
  • Cautery
  • Closure
• Customary supplies
  • Needles & dressings, etc.
• Local/Regional anesthetic
• Suture and staple removal
• Dressing changes, packing, splints, etc.

Contact Information

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