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When Is It OK to Bypass Medicare Edits?

Apply a modifier when it's appropriate, not automatically.

Automatically applying a modifier every time one's allowed is a surefire way to leave money on the table. Just as it's important that your coders know when a combination of codes warrants a bundling edit, it's crucial that they know when it's OK to bypass an edit.

Exceptions to the rule

Certain code combinations may warrant an exception based on clinical documentation. Many combinations of codes reflect a bundling edit, but a correct coding modifier indicator (CCM) will let the coder know whether a modifier may be applied to bypass the edits in cases, for example, when surgeons perform separate and distinct procedures.

A correct coding modifier indicator of 1 indicates that you may bypass an edit with a modifier, thus letting you report both services. A correct coding modifier indicator of 0 indicates that no separate payment will be made regardless of the modifier you apply. A correct coding modifier indicator of 9 indicates that the bundling edit is no longer applicable.

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When it comes to Medicare edits, coders have 2 tendencies. They either err on the side of caution when reviewing the edits or they don't understand when they should append a modifier to the CPT code to indicate a separate and distinct procedure that would otherwise be considered bundled. The better the coder knows the procedure and the more she understands the rationale behind the National Correct Coding Initiative edits, the easier she'll be able determine whether a modifier is applicable.

The NCCI was implemented to ensure consistent national correct coding across different states and jurisdictions, and to minimize improper coding that could potentially lead to inappropriate reimbursement. The NCCI identifies coding combinations that normally shouldn't be billed by the same provider for the same patient on the same day. The NCCI edits consist of pairs of HCPCS codes that are arranged into 2 tables — the Column 1/Column 2 Correct Coding Edits table and the Mutually Exclusive Edits table. A common mistake is to code with a "quick fix" mentality. By this we mean overlooking the correct coding modifier indicator. Don't code with blinders on. A tendency of NCCI edits users is to interpret the codes found in column 2 to be bundled at all times with codes found in column 1, thereby disregarding the CCM indicators. An understanding of the rationale behind the edits will ensure that correct coding becomes second nature.

Let's look at a few specialties where misinterpreting the NCCI edits can mean a loss in facility fees:

- **Gastroenterology.** Medicare edits bundle CPT 45380 *(Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple)* into CPT 45385 *(Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique)* but allows for a modifier (-59) if the biopsy of a polyp and the removal of polyp by snare technique are 2 separate and distinct procedures performed on 2 separate and distinct lesions.

CPT 45385 = $380.23

CPT 45380-59 = $380.23/2

Bypassing the Bundling Edit

Correct coding modifier indicator	Indicates that …
1	… the edit may be bypassed with a modifier, thus allowing both services to be reported.
0	… no separate payment will be made regardless of the application of a modifier.
9	… the bundling edit is no longer applicable.

• **Pain management.** Medicare edits bundle CPT 64483 *(Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level)* into CPT 62311 *(Injection, single, epidural or subarachnoid; lumbar, sacral [caudal])* considering 64483 as mutually exclusive. The correct coding modifier indicator (1) allows for a modifier (-59) to be appended to CPT 64483 when performed at a different level than the injection reported by CPT 62311. The physician's documentation should detail the specific levels and regions he is entering and injecting.

CPT 62311 = $295.98
CPT 64483-59 = $295.98/2

• **Orthopedics.** Medicare edits bundle CPT 29823 *(Arthroscopy, shoulder extensive debridement)* into CPT 29824 *(Arthroscopy, shoulder, surgical; distal claviculectomy)* at this time but allows for a modifier if the debridement is performed separate and distinct from the distal claviculectomy.

A coder unfamiliar with the Medicare edits and its conventions might report only CPT 29824 since CPT 29823 is listed in the Medicare edits as an integral component despite operative documentation to the contrary. On the flip side, a coder that understood the detailed operative description and understood when to apply the -59 modifier would report both CPT 29824 and 29823-59 and capture additional reimbursement. An important note: Documentation must describe extensive debridement in significant areas/sites separate and distinct from the area/site of the distal claviculectomy in order to report both codes.

CPT 29823-59 = $1,588.70
CPT 29824 = $1,070.42/2

• **Orthopedics.** Medicare edits bundles CPT 29807 *(Arthroscopy, shoulder, surgical; repair of SLAP lesion)* into CPT 29806 *(Arthroscopy, shoulder, surgical; capsulorrhaphy)* at this time, but allows for a modifier (-59) if the surgeon performs specific arthroscopic SLAP repair separate and distinct from the arthroscopic capsulorrhaphy and the capsulor-

Avoid These 5 Common Coding Mistakes

➤ **Applying a modifier to bypass the edits when a procedure is truly integral to the main procedure.** The application of the -59 modifier is applicable only in certain circumstances. The overuse of the -59 is a red flag to Medicare and the OIG.

➤ **Applying a modifier when applicable (separate and distinct procedure) to the wrong code.** The modifier should be applied to the code found in column 2 since it is the code that is deemed integral to the procedure under normal circumstances.

➤ **Memorizing code-specific edits.** CPT codes and NCCI edits are subject to changes annually or quarterly so memorizing code pair edits would be an exhaustive and fruitless undertaking to say the least.

➤ **Using obsolete edits.** Whether using paper or electronic versions of the edits, coders should ensure the edits are updated quarterly. In addition, coders should maintain or have access to previous quarterly edits in the event code selections need to be justified for claims adjudication or the more onerous audit rebuttals.

➤ **Not considering additional Medicare and NCCI Edits Resources.** CMS provides an electronic version of the NCCI policy manual that contains coding guidelines and reporting policies for many common procedures. I recommend that you review applicable chapters in addition to the tables titled Column 1/Column 2 and Mutually Exclusive.

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rhaphy is unrelated to the SLAP repair. Use caution when considering the application of a modifier. Remember the terms "separate" and "distinct."

CPT 29806 = $1588.70

CPT 29807-59 = $1,588.70/2

Medical necessity

While we may have navigated through our decision-making processes, let's not forget that medical necessity requirements will play a role in reimbursement. Local coverage determination policies provide documentation and medical necessity essentials for specific procedures. Your Medicare Administrative Contractor/Fiscal Intermediary may offer LCD policies that provide more specific coding, reporting and medical necessity directives for more common procedures. When you combine a working knowledge of the NCCI edits and CPT coding guidelines with detailed clinical documentation/medical record keeping, coders should be confident with final code selections. It will be these very resources and directives that will serve as back up should the coder need to show credible documentation supporting the decision making process. **OSM**

5 Questions to Ask When Coding Medicare Cases

1. Is the operative report coded correctly?

2. Is there an NCCI edit for these code sets?

3. What is the rationale behind the edit?

4. Does the correct code modifier indicator reflect that an edit may be bypassed with an appropriate modifier? If so, which modifier is the most appropriate?

5. Should the edit be bypassed (as in the case of a separate and distinct procedure) simply because the correct coding modifier indicator allows it?

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