Navigating NCCI and its Modifiers

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Disclaimer

• This PowerPoint presentation is an educational tool to provide basic information for coding. The information is the sole view of the author and was put together based on experience, research and expertise in the coding profession. It is not intended to be an exhaustive review and should not be considered a substitution for Coding Guidelines. The presenter does not accept any responsibility or liability with regard to errors, omissions, misinterpretation or misuse by the audience.
Objectives

• The presentation will educate on the National Correct Coding Initiative to ensure proper use of modifier 59 and X{EPSU} modifiers.

• It will also guide you through the steps to find the NCCI edits on the CMS website in order to equip you with the resources necessary for proper modifier usage.
What is NCCI?

- NCCI – National Correct Coding Initiative
  - NCCI Policy
  - NCCI Edits
    - Practitioner
    - Hospital
    Automated prepayment edits
Why was it developed?
CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together.
What is MUE?

• Medically Unlikely Edits are also prepayment edits which define the maximum number of units allowable under most circumstances for a single HCPCS/CPT code on a date of service.
How often is it updated?

- NCCI edits are updated quarterly
- NCCI policy is updated annually
- MUE tables are updated quarterly

- NCCI edits were implemented with DOS January 1, 1996
- MUEs were implemented January 1, 2007
History

• Prior to April 1, 2012, NCCI PTP edits were placed into either the “Column One/Column Two Correct Coding Edit Table” or the “Mutually Exclusive Edit Table”.

• On April 1, 2012, the edits in the “Mutually Exclusive Edit Table” were moved to the “Column One/Column Two Correct Coding Edit Table” so that all the NCCI PTP edits are currently contained in this single table.

Combining the two tables simplifies researching NCCI PTP edits and online use of NCCI tables.
How do I use NCCI?

• Look up the code pair on the NCCI table
  • Column 1
  • Column 2
Indicators

- “0” a modifier is not allowed and the code in the second column is either a component of the code in the first column or is mutually exclusive to the code in the first column.

- “1” a modifier, such as 59, is allowed if appropriate

- “9” codes can be billed together without a modifier
### Sample

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
<th>PTP Edit Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>29880</td>
<td>29877</td>
<td>20030301</td>
<td>*</td>
<td>0</td>
<td>Misuse of column two code with column one code</td>
</tr>
<tr>
<td>29880</td>
<td>G0289</td>
<td>20120101</td>
<td>*</td>
<td>1</td>
<td>HCPCS/CPT procedure code definition</td>
</tr>
</tbody>
</table>

- **29880** Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
- **29877** Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
- **G0289** Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee
11055 Paring or cutting of benign hyperkeratotic lesion (eg. Corn or callus); single lesion

11720 Debridement of nail(s) by any method(s); 1-5
Modifiers

- 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
Modifier 59 or X{EPSU}

• CPT® states:

“Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. 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.”
• “Treatment of the nail, nail bed, and adjacent soft tissue on the same toe or finger constitutes treatment of a single anatomic site.”

• “Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site.”

• “Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.”
Separate Procedure

- A procedure designated by the CPT code descriptor as a “separate procedure” is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)(separate procedure)
A physician performs and documents for both a Arthroscopic rotator cuff repair (29827) and an arthroscopic limited debridement in the shoulder (29822). 29827 is the column 1 code and 29822 is the column 2 code. The indicator is “1” with the PTP Edit Rationale of “Standards of medical / surgical practice”

29827 and 29822 can only be coded together when they are performed on contralateral shoulders. The appropriate modifier usage would be RT and LT, not 59.
Modifier 59 Flow Chart

A CMS CONTRACTOR

Does the procedure/service quality for the use of the 59 modifier?

Yes

Are you billing for two or more procedures that may be bundled under NCCI?

Yes

Is this procedure part of a NCCI code pair that has a modifier indicator of '0'?

Yes

Do NOT use the 59 modifier.

No

No

Modifier 59 is NOT required.

No

Is NCCI modifier indicator a '1'?

Yes

Is another more specific and descriptive modifier available to explain the separate status?

Yes

Use another appropriate or already established modifier (e.g., RT, LT).

No

Append the 59 modifier to component (minor) code (ensure documentation supports separate status).
Modifier X{EPSU}

- **XE Separate Encounter**: A service that is distinct because it occurred during a separate encounter.

- **XS Separate Structure**: A service that is distinct because it was performed on a separate organ/structure.

- **XP Separate Practitioner**: A service that is distinct because it was performed by a different practitioner.

- **XU Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service.
Four new HCPCS modifiers have been established to provide greater reporting specificity than modifier -90 on claims with dates of service on or after January 1, 2015. They are:

- **XE** - Separate encounter: a service that is distinct because it occurred during a separate encounter
- **XP** - Separate practitioner: a service that is distinct because it was performed by a different practitioner
- **XS** - Separate structure: a service that is distinct because it was performed on a separate organ / structure
- **XU** - Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service

Modifier -90 will remain a valid modifier. Use of the new XE, XP, XS, and XU modifiers is currently optional. However, providers may choose to use them to specify more clearly the clinical situations in which modifier -90 is now reported.

These modifiers may be used for clinical situations in which two HCPCS/CPT codes are reported by the same provider on the same date of service and that are currently indicated by appending modifier -99 “Distinct Procedural Service” to a HCPCS/CPT code.

These modifiers should not be used unless the proper criteria for use of the modifier are met. Documentation in the medical record must support the use of any modifier that is used.

Provider use of these modifiers will be monitored for abuse and when appropriate, referred to Program Integrity for detailed review and potential recovery of overpayments.

For questions related to this information as it pertains to Legacy Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 479-2783 or (125) 924-5640.
United Healthcare

The Centers for Medicare and Medicaid Services (CMS) has created four new healthcare common procedure coding system (HCPCS) modifiers to selectively identify subsets of modifier 59 (distinct procedural services) for use, effective Jan. 1, 2015. They are:

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XP Separate Practitioner: A service that is distinct because it was performed by a different physician.
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XU Unusual Non-Overlapping Service: A service that is distinct because it does not overlap usual components of the main service.

These modifiers, collectively referred to as X [EPSU] modifiers, define specific subsets of modifier 59. Like CMS, United Healthcare will continue to recognize modifier 59; however, current procedural terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. In addition, the X [EPSU] modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line.

CMS will continue to recognize modifier 59 but may selectively require a more specific X [EPSU] modifier for billing certain codes at high risk for incorrect billing. For example, a particular national correct coding initiative (NCCI) procedure to procedure code pair edit may be identified as payable only with the XE separate encounter modifier but not the 59 or other X [EPSU] modifiers.

United Healthcare will recognize these new modifiers, effective for dates of service on and after Jan. 1, 2015. Please reference the following table to find out when the new modifiers will be considered in administering United Healthcare’s reimbursement policies.

<table>
<thead>
<tr>
<th>Policy</th>
<th>HCPCS Modifiers considered in lieu of Modifier 59</th>
<th>Effective for dates with dates of service on or after those dates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>XE and XU</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>Bilateral</td>
<td>X1</td>
<td>Jan. 1, 2015</td>
</tr>
<tr>
<td>Laboratory</td>
<td>XG, XO, XS, and XU</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>MaxiCare</td>
<td>XG, XS, and XU</td>
<td>Jan. 1, 2015</td>
</tr>
<tr>
<td>Obstetrical</td>
<td>XE, XS, and XU</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>Pediatric and Neonatal Critical Care Services</td>
<td>XG and XU</td>
<td>New policy becomes effective March 1, 2015 DCGS</td>
</tr>
<tr>
<td>Procedure to Modifier</td>
<td>XE, XO, XS, and XU</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>Professional-Technical</td>
<td>XE, XO, XS, and XU</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>Radiology</td>
<td>XE</td>
<td>Jan. 1, 2015</td>
</tr>
<tr>
<td>Abnormal Imaging Reduction</td>
<td>XE</td>
<td>Feb. 15, 2015</td>
</tr>
<tr>
<td>Abnormal Imaging</td>
<td>XG, XO, XS, and XU</td>
<td>Feb. 15, 2015</td>
</tr>
</tbody>
</table>
Commercial and Medicare Advantage Payment Policy

In addition to this policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana plans accept HCPCS modifiers -XE, -XP, -XS, and -XU. Each of these modifiers should only be used to accurately describe the service that occurred. Until CMS determines when these modifiers must be used in place of modifier -59, Humana will accept either modifier -59 or one of these modifiers accurately appended to a service code.
Modifiers XE, XP, XS and XU

The primary purpose of modifier 59 is to report two or more procedures that are being performed at different anatomic sites or for different patient encounters by the same provider on the same date of service.

- According to the Centers for Medicare & Medicaid Services (CMS), “The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter.”

- Modifier 59 should not be used to bypass an edit unless the proper criteria for its use are met and the documentation in the patient’s medical record clearly supports this criteria and the use of modifier 59.

CMS has established four new HCPCS modifiers to define specific subsets for modifier 59. For professional claims, Blue Cross will allow the same incidental and mutually exclusive edit overrides for the new 2015 modifiers XE, XP, XS and XU as it does for modifier 59.

- XE - Separate Encounter - A service that is distinct because it occurred during a separate encounter
- XP - Separate Practitioner - A service that is distinct because it was performed by a different practitioner
- XS - Separate Structure - A service that is distinct because it was performed on a separate organ structure
- XU - Unusual Non-Overlapping Service - The use of a service that is distinct because it does not overlap usual components of the main service.

Note: Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, use modifier 25.
NCCI Policy Manual

• Arranged by Chapters corresponding to a separate section of the CPT® manual.

• Includes a chapter for general correct coding policies – Chapter 1

• Addresses HCPCS Level 2 codes in Chapter 12

• Addresses Category III CPT codes in Chapter 13
Integral Components

• Cleansing, shaving and prepping of skin
• Draping and positioning of patient
• Insertion of IV access for medication administration
• Insertion of urinary catheter
• Wound irrigation
• Surgical closure and dressings
• Lysis of adhesions

THIS IS NOT AN ALL INCLUSIVE LIST
NCCI Guidelines

• A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services.

• A physician should not fragment a procedure into component parts.

• A physician should not unbundle a bilateral procedure code into two unilateral procedure codes.

• A physician should not unbundle services that are integral to a more comprehensive procedure.
The provider performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpino-oophorectomy

A. 58262 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)

B. 58260 Vaginal hysterectomy, for uterus 250 g or less

C. 58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

D. Both B and C

(Hint 58720 is a column 2 code to 58260 with an indicator of “0”)

(58260 and 58720 are both column 2 codes to 58262)
A physician performs a bilateral mammography.

A. 77065-RT and 77065-LT Mammography; unilateral with anatomic modifier

B. 77065-50 Mammography; unilateral with bilateral modifier

C. 77065 x 2 Mammography; unilateral with a quantity of two

D. 77066 Mammography; bilateral
NCCI Guidelines

• More extensive procedures
  • Not separately reportable if performed at the same patient encounter on the same anatomic site.
    • A “partial” procedure is not separately reportable with a “complete” or “total” procedure.
    • A “unilateral” procedure is not separately reportable with a “bilateral” procedure.
    • A “single” procedure is not separately reportable with a “multiple” procedure.
    • A “with” procedure is not separately reportable with a “without” procedure.
General Principles

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

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

- The component service is not a separately distinguishable procedure when performed with the comprehensive service.
Multiple approaches to the same procedure are mutually exclusive of one another and should not be reported separately.

- both a vaginal hysterectomy and abdominal hysterectomy should not be reported separately.

- Scope converted to open. Only code for the successful procedure
Biopsy

• If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

• If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination.

• If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.
Arthroscopy

- Update for 2017
- Shoulder arthroscopy procedures include limited debridement (29822) even if limited debridement is performed in a different area of the same shoulder than the other procedure.
- Extensive debridement (29823) is also included with 3 exceptions if the debridement is performed in a different area of the same shoulder
  - 29824 arthroscopic claviculectomy
  - 29827 arthroscopic rotator cuff repair
  - 29828 arthroscopic biceps tenodesis
Complications

• Treatment of a complication of a primary surgical procedure is not separately reportable:
  
  • if it represents usual and necessary care in the operating room during the procedure or
  
  • if it occurs postoperatively and does not require return to the operating room.
During Operation

- The administration of fluids and drugs during the operative procedure is included in the global surgical package.

- CPT codes 96360-96376 should not be reported separately.

- OPPS considers 96360-96376 inclusive and not separately reportable.

- Cardiopulmonary monitoring is integral to the procedure

  - (e.g. 93000-93010, 93040-93042, 94760-94761, 94770)
Nuclear Medicine

- CPT code 36000 *introduction of needle or intracatheter into a vein* is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.) Other integral services do not have specific CPT codes.
“When a comparative imaging study is performed to assess potential complications or completeness of a procedure (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the professional component of the CPT code for the post-procedure imaging study is not separately payable and should not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.”
Family Codes

- CPT® codes followed by one or more indented CPT® codes

CPT code 70120  Radiologic examination, mastoids; less than three views per side
CPT code 70130  complete, minimum of three views per side
Evaluation and Management

- Same day as a major surgery (90 day global)
  - Modifier 57
- Same day as a minor surgery (0 or 10 day global)
  - Modifier 25
  - Diagnosis code
  - New patient status
- Unrelated E/M during a post operative period
  - Modifier 24
Software Edit Pitfalls
Steps

- NCCI Manual

- NCCI Edits
  - [www.cms.gov](http://www.cms.gov) -> Medicare -> National Coding Initiative Edits -> PTP Coding Edits -> Choose hospital or physician and code range you are reviewing.
Click on the Medicare tab
Scroll down to the Coding section
Click on National Correct Coding Initiative Edits
Guidelines – Scroll down and click on the NCCI Policy Manual for the current year.
Click on the manual to open the zip file.
As of October 8, 2014, the PTP test files have been modified for 508 compliance purposes. They now include headers and are tab delimited.

**Related Links**

| Hospital PTP Edits v2.3 effective October 1, 2016 (465,618 records) | 00017100027 - 79999938952 |
| Hospital PTP Edits v2.3 effective October 1, 2016 (375,798 records) | 50000072137 - 4669486570 |
| Hospital PTP Edits v2.3 effective October 1, 2016 (332,587 records) | 59010002137 - 79999938950 |
| Hospital PTP Edits v2.3 effective October 1, 2016 (121,873 records) | 09000000021 - 46070585079 |
| Practitioner PTP Edits v2.3 effective October 1, 2016 (868,511 records) | 00017100027 - 28999903554 |
| Practitioner PTP Edits v2.3 effective October 1, 2016 (498,019 records) | 30000002137 - 4669486570 |
| Practitioner PTP Edits v2.3 effective October 1, 2016 (169,992 records) | 50010002137 - 79999938974 |
| Practitioner PTP Edits v2.3 effective October 1, 2016 (179,552 records) | 09000000021 - 46070585079 |
| Hospital PTP Edits v2.0 effective January 1, 2017 (1,034,321 records) | 00017100027 - 79999938952 |
| Hospital PTP Edits v2.0 effective January 1, 2017 (465,751 records) | 00000000021 - 4669486570 |
| Hospital PTP Edits v2.0 effective January 1, 2017 (303,084 records) | 59010002137 - 79999938950 |
| Hospital PTP Edits v2.0 effective January 1, 2017 (121,542 records) | 09000000021 - 46070585079 |
| Practitioner PTP Edits v2.0 effective January 1, 2017 (429,052 records) | 00017100027 - 28999903554 |
| Practitioner PTP Edits v2.0 effective January 1, 2017 (574,190 records) | 2000000021 - 3999996570 |
| Practitioner PTP Edits v2.0 effective January 1, 2017 (456,647 records) | 4000000021 - 5999996570 |
| Practitioner PTP Edits v2.0 effective January 1, 2017 (501,820 records) | 6000000021 - 80075860079 |

Page last Modified: 12/09/2016 12:18 PM

Help with File Formats and Flag Issues
Summary

• A HCPCS/CPT® code may be reported if and only if all services described by the code are performed.

• A physician should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed.

• HCPCS/CPT® code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) should not be reported separately.

• If the HCPCS/CPT® codes do not correctly describe the procedure(s) performed, they physician should NOT report the code that most closely describes the procedure(s) performed.
RESOURCES
How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

To learn more... If you find this How To booklet helpful, then you may wish to receive the other booklets in this series. To make those available, go to the Publications page at http://www.cms.gov/medicare, and search for items containing the words "How To."

http://www.cms.gov/medicare/
MODIFIER 59 ARTICLE

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define two Medicare Common Procedure Coding System (HCPCS) Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. For PTP edits that have a Correct Coding Modifier Indicative (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 3, for general information about the NCCI program, PTP edits, CCMI, and NCCI-associated modifiers.) One function of NCCI/PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The CPT Manual defines modifier 59 as follows:

“Distinct Procedural Services: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services, that are not usually reported together, but are appropriate under the circumstances. Documentation must support a different service, different procedure or surgery, different site or organ system, separate incision, separate lesion, or separate injury (or area of injury in consecutive 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. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, use modifier 25.”

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.
Check Your Local MAC
Questions
Thank you!

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