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AAOE eNEWS

NCCI Guidelines are out for 2013

Margie Scalley Vaught, CPC, CPC-H, CPC-I, CCS-P, PCE, MCS-P, ACS-EM, ACS-OR

The new 2013 Correct Coding Initiative (CCI) edits just came out and you will want to get your hands on the full chapters and read over them. There are some things you need to be aware of for any of your payers/carriers that use CCI edits. Here is the link to obtain these edits: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Here are some of the highlights:

Chapters One and Four

You will find that you will want to read over the information regarding when you can support modifier 25 and when you should not be reporting a separate EM service with a minor procedure. Here is a small portion of that section:

> "For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery that do not require additional trips to the operating room. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").
>
> If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. **E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure**. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

> The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles."

Confusing paragraph

You will find that the below paragraph is in just about all the different chapters of the NCCI guidelines. When checking with NCCI about what kind of 'providers' are they talking about that are being paid under OPPS, the reply I received on December 17, 2012 states that this paragraph will be revised on or before January 1, 2013 so to watch for the new wording. For now be aware of this paragraph and then keep an eye out for the new wording which hopefully will give more insight to who these 'providers' are:

> "Providers reporting services under Medicare's outpatient hospital prospective payment system (OPPS) must report all services performed including those that are not separately payable. This requirement applies to services not payable due to NCCI edits. Providers should be careful to avoid inappropriately appending NCCI-associated modifiers to codes to improperly bypass an NCCI edit."

Chapter 4 BIGGIES

All of Chapter 4 deals with MS coding and billing so this is an important chapter for orthopaedic offices. There are sections relating to fracture care and one area where it appears Medicare is going to be cracking down which is closed fractures without manipulation. In handouts from the AMA symposium in November 2012, there was a section of high-volume/concerned codes that CMS was worried about. Two of those codes were for closed treatment of a fracture without manipulation, one was for the proximal humerus and the other was for metatarsal fractures. So even though the CPT code description states 'each' such as with code 28470, you may find that CMS won't allow multiple reporting based on this new paragraph in chapter 4 of the NCCI 2013 guidelines:

> "14. <u>If a cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture without manipulation CPT code may be reported</u>.

Here are some additional guidelines however don't forget to refer to the above-referenced URL for the full context:

> "5. Procedures performed on fingers should be reported with modifiers FA, F1-F9, and procedures performed on toes should be reported with modifiers TA, T1-T9. The MUE values for many finger and toe procedures are one (1) based on use of these modifiers for clinical scenarios in which the same procedure is performed on more than one finger or toe."

> "11. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29866-29889). With two exceptions HCPCS code G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee) may be reported with other knee arthroscopy codes. Since CPT codes 29880 and 29881 (Surgical knee arthroscopy with meniscectomy including debridement/shaving of articular cartilage of same or separate compartment(s)) include debridement/shaving of articular cartilage of any compartment, HCPCS code G0289 may be reported with CPT codes 29880 or 29881 only if reported for removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 should not be reported for removal of a loose body or foreign body or debridement/shaving of articular cartilage from the same compartment as another knee arthroscopic procedure."

> "13. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22520-22522 describes percutaneous vertebroplasty. CPT code 22520 describes percutaneous vertebroplasty of a single thoracic vertebral body. CPT code 22521 describes percutaneous vertebroplasty of a single lumbar vertebral body. CPT code 22522 is an add-on code describing percutaneous vertebroplasty of each additional thoracic or lumbar vertebral body. If a physician performs percutaneous vertebroplasty on contiguous vertebral bodies such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body should be reported with CPT code 22522. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22520 and 22521."

"22. **CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints**."

"24. CPT code 38230 (bone marrow harvesting for transplantation) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code. CPT code 38230 is used to report the procurement of bone marrow for future bone marrow transplantation."

"27. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM."