NCCI Edit Resolution

More Art Than Science

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One reimbursement challenge often overlooked, and perhaps even more misunderstood, is Medicare's utilization of National Correct Coding Initiative (NCCI) edits. Per the Centers for Medicare and Medicaid Services (CMS), the purpose of the edits is to prevent improper Part B payment when incorrect code combinations are reported on a claim. The NCCI contains one table of edits for physicians / practitioners and one table of edits for outpatient hospital services.

What is an NCCI edit?

NCCI edits are generally identified by HCPCS code pairs. A combination of codes charged and billed on the same date of service (or during the same episode of care) by the same provider for the same patient may not be appropriately paired together for billing. Payment for one of the services (test, exam, visit, or procedure) is included with the payment for another service performed that day because:

- One code is considered to be "Comprehensive" and the other is a "Component" code.
  - For example, an EKG performed during a Stress Test is considered an integral component of the Stress Test.
- One code is considered to be "Mutually Exclusive" with another code on the claim.
  - A unilateral Mammogram is considered mutually exclusive with a bilateral Mammogram.

These two types of edits have been combined into one file that contains CMS identified "procedure-to-procedure" (PTP) codes either as Column 1 (payable) or Column 1 (not separately payable).

In contrast to traditional fee-for-service reimbursement where providers are paid separately for each service, CMS has now adopted an "episode-of-care" payment standard for the Outpatient Prospective Payment System (OPPS). This value-based bundled (packaged) payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Examples of episodes of care for which a single, bundled payment may be made include outpatient Observation and identified surgical or invasive procedures. NCCI edits that review the HCPCS codes billed on the claim are utilized to ensure charge capture complies with the CMS requirements for bundled payment.

How have 2018 and 2019 Medicare regulations complicated the utilization and resolution of NCCI edits?

In addition to the standard episode of care for bundled payment, CMS added a record number of "packaged" services for 2018. "Packaging," or grouping payment of dependent, ancillary, supportive, and adjunctive items and services into the payment for the associated primary procedure or service, is a critical feature of the OPPS. Separate payments are not made for packaged services, which are considered an integral part of another service that is paid under the OPPS. And, for this year, CMS has increased the number of Comprehensive and Composite APCs (Ambulatory Payment Classifications) as well as increased other APC Status Indicators that receive packaged payment. Comprehensive APCs provide all-inclusive payments for certain procedures and services. For 2019, this policy not only packages payment for all items and services typically packaged under the OPPS; it also packages payment for other items and services under the OPPS for the first time. Approximately 65% of payable HCPCS codes under OPPS, may be packaged depending upon other services billed on a claim.

2019 Decision on Adding Modifier or No Modifier

When hospitals initially began being reimbursed based on NCCI edit requirements, under specific circumstances, the addition of a Modifier would allow the Column 2 code to process and pay. However, for 2019, due to the CMS focus on episodic payment at the claim level, the Column 2 code is either "N" (Incidental) status or has been assigned a Status Indicator as part of a packaged payment. In addition, most hospital outpatient Lab tests (except for genetic testing and some pathology tests) are no longer separately payable even without an NCCI edit code pairing, so Modifier 91 (repeat lab test on the same date of service) does not generate additional payment. The imaging modalities (X-ray, CT, MRA and MRI, myelography and ultrasound) are no longer separately paid when another service is billed on the claim – even when Modifier 59 (distinct, separate service) is appended.

Based on the limited number of codes that will be separately reimbursed – even after evaluation of the medical record by a coder or qualified staff member for addition of a compliant modifier – specific NCCI code pairs should be identified for further assessment, as the charge for the Column 2 code may be added to the Column 1 code for combined billing, and the Column 2 code removed from the claim. To ensure appropriate use of time and effort, no packaged code should require modifier review.

PACKAGED APC STATUS INDICATORS FOR 2019

J1
Comprehensive APCs

J2
Multiple J1 and other packaged APCs

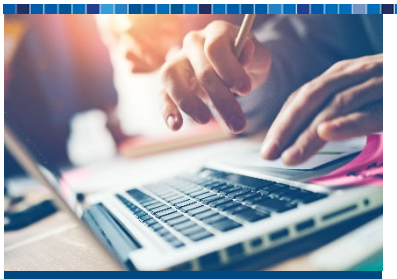
N
Incidental services – considered reimbursed under some other service on the claim, no separate payment

Q1
STVX-packaged (Significant, Surgical, Visit or Ancillary) outpatient service also billed on the same date of service or within the claim episodic range

Q2
T-packaged codes (Surgical procedure or service that is reduced for multiples)

Q3
Composite codes subject to payment as part of a Composite APC

Q4
Laboratory tests subject to packaging



Good News: Soft-coded Services Include Modifier(s)

Experience has proven that NCCI edits for code pairs that billers are seeing reject or error out are for CDM generated (hard-coded) charges and codes.

Generally, if a coder is reviewing the medical record (soft-coding), and codes two or more surgical or invasive procedures, the coder will append the modifier, if appropriate, to the Column 2 code; so, these do not error out.

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The "Art" of Modifier Review for 2019

Since these edits are most often triggered at the time a claim drops in the billing system, the following preventive and follow-up procedures are recommended:

- Develop an NCCI resolution specialist. Edits change quarterly and are often facility or practice specific, so a resource with charge capture, coding, and billing expertise is needed.
- Maintain an electronic spreadsheet list of current NCCI edits with a bulleted step-by-step resolution process for each code pair as developed by your NCCI resolution specialist. This spreadsheet should be a living breathing document as new edit pairs may appear at any time. Your NCCI resolution specialist may benefit from collaboration with a clinical team member who is familiar with the procedures followed in ordering, documenting and providing the service.
- Ensure billers understand the edit messages – do not allow billers to add modifiers to bypass NCCI edits.
  - Caution – The edit may state the claim will process "if a modifier is added," but additional documentation is mandatory to support the utilization of the modifier and to explain the circumstances why both services (codes) should be paid.
  - Inaccurate or "always appended" modifiers may serve as a red-flag that identifies claims for pre-payment review.
- Before billers make a request for a coder to review a claim to determine if a modifier can be added, billers should verify if the modifier will generate a separate (additional) payment. This important detail should be included in your spreadsheet discussed above. Following this guideline along with regular education will ensure billers understand the requirements and rationale for sending claims for a coding review.
- Train, train, train . . . hold at a minimum, quarterly training sessions for physicians and other providers, clinical staff members who may affect charge capture, coders, billers and follow-up specialists.

A Compliant and Optimum Reimbursement Path

By following the suggestions above, NCCI edits can be appropriately resolved for compliant payment; however, the larger concern may be ensuring reimbursement is optimized. Audits should be performed to evaluate the HCPCS codes being charged and billed on all claims – not just Medicare. But Medicare presents additional complications due to specific APC assignments to codes. If a Comprehensive APC is performed, but a lesser complexity code is billed; reimbursement will be reduced. All services should be charged, NCCI edit pairs should be correctly resolved, and payment should be evaluated to determine accuracy.