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Part B Insider (Multispecialty) Coding Alert

NCCI Edits: 3 Essential CCI Changes That You Should Study Right Now

Fortunately, some of them can be separated with modifiers.

The latest round of CCI (Correct Coding Initiative) edits went into effect April 1, with several additions that you need to watch. Read on for the breakdown by procedure: epidural injections, TEE, and joint injections.

Don't Assume You Can Report Flouro Guidance With Epidurals

One new set of bundling edits lists epidural codes 62310-62319 as Column 1 procedures with 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid]) as the Column 2 code. The descriptors for the affected epidural procedures are as follows:

- 62310 – Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62311 – ... lumbar or sacral (caudal)
- 62318 – Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62319 – ... lumbar or sacral (caudal).

"Though just released with CCI 21.1, this new edit is retroactive back to Jan. 1, 2015," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** of MJH Consulting in Denver, Co. "This is in support of the 2015 Medicare Physician Fee Schedule that stated Medicare was going to revert back to the 2013 RVUs for these codes but that image guidance would be prohibited from being separately paid with these epidural codes."

The Medicare stance is contradictory to CPT® directives. Because the first quarter CCI edits for 2015 did not include a bundling edit, some practices mistakenly billed 77003 with these epidural codes and were paid.

Point to ponder: "They thought that because they were paid by Medicare, it was appropriate to continue to bill these separately," Hammer explains. "Practices that have been paid by Medicare in 2015 for 77003 with the 62310-62319 should consult their healthcare attorney about refunding the inappropriate payment for 2015 dates of service that was previously processed. Medicare contractors will likely go back through their payment files and be reviewing any payment for 77003 with these codes for the same session and request a refund."

You can potentially bypass the bundling edit between 77003 and codes 62310-62319 with a modifier, but Hammer says the provider would need to use the fluoroscopic guidance with a different procedure from the epidural.

Mark When Myelography Gets Bundled With TEE

CCI 21.2 also bundles four new myelography codes with transesophageal echocardiography.

- 62302 – Myelography via lumbar injection, including radiological supervision and interpretation; cervical
- 62303 – ... thoracic

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- 62304 ... lumbosacral
- 62305 ... 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical).

According to the edits, you should not submit these codes with 93355 (Echocardiography, transesophageal [TEE] for guidance of a transcatheter intracardiac or great vessel[s] structural intervention[s] [e.g.,TAVR, transcathether pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure] [peri-and intra-procedural], real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D).

Again, however, these myelography/TEE edits carry a modifier indicator of "1," so there might be times when you can legitimately report both services during the same patient encounter.

"Things I've seen recently seem to indicate that 93355 is bundled with all anesthesia services," says **Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I,** owner of Perfect Office Solutions in Leesburg, Fl. "I've been told that the ASA is working on this issue."

Stay Away From Follow-Up Ultrasound With New Injection Codes

If your provider sometimes administers joint injections, you'll also want to pay attention to several edits related to three new codes introduced in January:

- 20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting
- 20606 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
- 20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting.

CPT® coding guidelines already instruct you to not report these codes with related procedures 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance) or 20611 (...with ultrasound guidance, with permanent recording and reporting) in conjunction with 27370 (Injection of contrast for knee arthrography) or 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation). You can, however, submit an additional code for fluoroscopic, CT, or MRI guidance when applicable.

New edit: Now, under CCI 21.1, you cannot report 20604, 20606, or 20611 with 76970 (Ultrasound study follow-up [specify]). The injection procedures are listed as the Column 1 codes, which means they include the work associated with 76970. As such, you only include the injection code on your claim.

Modifier status: The edits carry a modifier indicator of "1," meaning that you might be able to append a modifier to 76970 and report both procedures. Verify the circumstances and ensure that you have full documentation supporting both codes before submitting a claim this way.

"In order to use a modifier to bypass the CCI edit, the provider would need to complete the procedure during a different session or at a different anatomic area from the joint injection site," Hammer says. "That being said, pain management wouldn't typically be using 76970. Rather, they would use either the extremity or spine ultrasound code."

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