You Asked What?
Answers to Some of Your Questions

Nannette Orme  CPC, CCS-P, CPMA, CEMC
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Optum360 customers ask us questions.

- We will share some of the interesting questions you ask us and our answers.
- Some of our favorite questions include code descriptions, CCI edits, modifiers, and the differences between CPT® and CMS instruction.
- All of this information is clarified in Optum360 electronic and print products.
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Favorite questions ONE

• Per CPT® 77063 can be used in conjunction with 77057, but there is a CCI edit not allowing these two codes. Help, what do I do?

• 77057 Screening mammography, bilateral (2-view study of each breast)

• 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
Favorite questions ONE, continued

77063 and 77057 facts

- The CPT® codes are copyrighted by the American Medical Association (AMA) and they have specific coding guidelines.
- Code 77063 is an add-on code and can never be reported alone and must be reported with a primary procedure.
- The CPT guidelines below code 77063 state “Use 77063 in conjunction with 77057.”
77063 and 77057 facts

• The Correct Coding Initiative (CCI) is created and maintained by Correct Coding Solutions, LLC, under contract with the Centers for Medicare and Medicaid Services (CMS).

• The edits *may* rely on CPT® descriptions or be based on Medicare policy.

• The CCI guidelines, page IX–8 a new guideline for 2016 states:

  15. *CPT® code 77063 is an add-on code describing screening digital tomosynthesis for mammography. Since this procedure requires performance of a screening mammography producing direct digital images (HCPCS code G0202), CPT® code 77063 may be reported with HCPCS code G0202. However, CPT® code 77063 should not be reported with CPT® code 77057 which describes screening mammography using radiography.*
Favorite questions ONE, continued

**77063 and 77057 resolution**

- Medicare code 77063 should be reported with code G0202.
- Private payers may accept 77057 and 77063.
- This is another instance where CPT® guidelines and CMS guidelines are not consistent.
- Individual payers may need to be contacted regarding their preferred billing and guidelines.
Favorite questions TWO

- Is it valid to report modifiers with unlisted procedure codes, for example CPT® 49329 and modifier 50, LT or RT?

- 49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
Customer supplied support for not reporting modifiers with unlisted codes:

• Modifiers are used to indicate that a performed service or procedure identified by a specific CPT® code has been altered by some circumstance but not changed in its definition. It is not appropriate to append modifiers to unlisted procedure codes because the unlisted procedure codes in the CPT code book do not describe specific procedures. Instead, when reporting an unlisted code to describe a procedure or service, or supporting documentation (e.g., procedure report) should be submitted to provide an adequate description of the nature, extent, need for the procedure, time, effort and equipment necessary to provide the service.

• CPT Assistant, September 2005, pages 9–11.
Favorite questions TWO, continued

Unlisted code with modifiers facts:

- Medicare physician fee schedule (MPFS)
- Code 49329

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>STATUS</th>
<th>MEDICARE</th>
<th>MULT</th>
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<th>ASST</th>
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<td>49329</td>
<td></td>
<td>Laparo proc abdm/per/oment</td>
<td>C</td>
<td></td>
<td>2</td>
<td>1</td>
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<td>1</td>
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</table>

- Mult Proc 2= Standard payment adjustment rules for multiple procedures apply
- Bilat Surg 1= 150% adjustment for bilateral procedures applies
- Asst Surg 2= Assistant at surgery may be paid
- Co-Surg 1= Co-surgeons could be paid with supporting documentation by report
- Team Surg 1= Team surgeons could be paid with supporting documentation by report
Favorite questions TWO, continued

Unlisted code with modifiers facts:

- AR  Physician provider services in a physician scarcity area
- Q6  Service furnished by a locum tenens physician
- SA  Nurse practitioner rendering service in collaboration with a physician
Favorite questions TWO, continued

Unlisted code with modifiers facts:

• **Question**: A laparoscopic cholecystectomy with extensive lysis of intra-abdominal adhesions was performed. The surgeon documented the following: “Marked adhesions intra-abdominally” and “Abdominal adhesions were slowly and carefully taken down. This took approximately one hour to clear all adhesions.” In addition to the code for the laparoscopic cholecystectomy, we reported code 49329 for lysis of the adhesions. What would be the appropriate code to report?

• **Answer**: Extensive adhesions that significantly complicate the performance of the primary procedure may be reported by appending Modifier 22, *Increased Procedural Services*, to the definitive procedure code. Documentation must reflect the additional work required for the removal (lysis) of dense adhesions. It would not be appropriate to report the unlisted code. You may also wish to contact your local third-party payers for specific reimbursement and payment policy guidelines as they may differ from CPT® guidelines.

• CPT Assistant, October 2013, page 18.
Favorite questions TWO, continued

Unlisted code with modifiers resolution:

• More recent CPT® Assistant guidelines indicate that it is appropriate to report modifiers with unlisted codes, specifically 49329.

• The MPFS indicates it is appropriate to report with modifiers 50, 51, 80.

• There are other modifiers that would also be appropriate dependent upon the specific circumstances of the surgical session.
Favorite questions THREE

• Please see NCCI edit allowed 1 for this coding combination (94660 and 99213). EncoderPro is reporting Modifier 0 incorrectly.

• 94660 Continuous positive airway pressure ventilation (CPAP), initiation and management.

• 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
### Favorite questions THREE, continued

**Code 94660**

Code 99213(column 1) has a CCI conflict with code 94660(column 2). A modifier is not allowed to override this relationship.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Work RVU</th>
<th>PE RVU</th>
<th>MP RVU</th>
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Favorite questions THREE, continued

**Customer-supplied support**

- Modifier 0=not allowed
  1=allowed
  9=not applicable

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<th>Code</th>
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<th>End Date</th>
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<td>20151231</td>
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CPT® Manual or CMS manual coding instructions
Favorite questions THREE, continued

CCI Edit 94660 and 99213 facts

- 5. Pursuant to the Federal Register (Volume 58, Number 230, 12/2/1993, Pages 63640-63641), ventilation management CPT® codes (94002-94004 and 94660-94662) are not separately reportable with evaluation and management (E&M) CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

# Favorite questions THREE, continued

## CCI Edit 94660 and 99213 facts

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
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</table>
Favorite questions THREE, continued

CCI Edit 94660 and 99213 resolution

• The client referenced a line out of the 22.0 version effective for dates of service January 1 through March 31, 2016.

• This line uses code 94660 as the column 1 code and 99213 as the column 2 code.

• Notice that the effective date for this edit is January 1, 2014, and the END date for this edit is December 31, 2015. This edit is no longer valid as of December 31, 2015.

• In the NCCI version 22.0 there is a new edit with code 99213 as the column 1 code and 94660 as the column 2 code and a value of “0” assigned. This indicates that a modifier is not allowed.

• NCCI Policy Manual supports the current edit and displays correctly.

• A modifier is not allowed to over-ride the CCI edit.
Favorite questions FOUR

• Your description of code 90644 is incorrect. It should be:

• Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2–18 months of age, for intramuscular use
Favorite questions FOUR, continued

90644 facts

• Snapshot of AMA’s CPT® book

#▲ 90644 Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-18 months of age, for intramuscular use

\[ CPT \text{ Changes: An Insider's View 2011, 2012, 2016} \]
\[ CPT \text{ Assistant Mar 11:4, Aug 13:10} \]

• Display in EncoderPro

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<th>🏥</th>
<th>📷</th>
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Favorite questions FOUR, continued

90644 facts

- AMA errata


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<thead>
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<th>90644 Category I Medicine Vaccines, Toxoids</th>
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<tr>
<td># ▲ 90644 Meningococcal conjugate vaccine, serogroups C &amp; Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks 2-18 months of age, for intramuscular use</td>
<td>Effective 01/01/2016</td>
</tr>
</tbody>
</table>

Revise code 90644 to expand the age range to 6 weeks-18 months of age from the current age for better alignment with the current FDA-approved label.
Favorite questions FOUR, continued

90644 resolution

• The AMA releases “Errata and Technical Corrections” to the CPT® book.

• The errata may be released multiple times during the year.

• 2016 errata dates:
  – November 13, 2016
  – December 17, 2016
  – February 16, 2016

• Note that sometimes a different effective date is given for a correction.

• It is important to regularly check for updates or subscribe to receive AMA errata email notification.

• Optum360 monitors the errata to be sure our data is correct.
Favorite questions FIVE

• We provided two hours of psychotherapy to the patient. We reported with code 90837 x 2 and it was denied. Can you tell me why?

• 90837 Psychotherapy, 60 minutes with patient and/or family member.
Favorite questions FIVE, continued

90837 facts

• CPT® page 584:
  “In reporting, choose the code closest to the actual time (i.e., 16–37 minutes for 90832 and 90833, 38–52 minutes for 90834 and 90836 and 53 or more minutes for 90837 and 90838).”
  “(Use the appropriate prolonged services code (99354, 99355, 99356, 99357) for psychotherapy service not performed with an E/M service of 90 minutes or longer face-to-face with the patient)”

• CPT page xv:
  “A unit of time is attained when the mid-point is passed…When codes are ranked in sequential typical time and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”
Favorite questions FIVE, continued

90837 facts

• There is a medically unlikely edit (MUE) of 1 assigned to code 90837 indicating that this service should only be reported once per day.

• What about modifiers?

• GD units of service exceeds medically unlikely edit value and represents reasonable and necessary services.

• XE separate encounter.
Favorite questions FIVE, continued

90837 recommendation

• 90837  Psychotherapy, 60 minutes with patient and/or family member.

• 99354  Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient evaluation and management of psychotherapy service).

• Note: If the psychotherapy is 51–89 minutes, only 90837 would be reported.

• Individual payers may have their own payment guidelines regarding psychiatric services or coverage policies.
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Our commitment

• Commitment to accuracy

• Ask the questions:
  – We research and respond to all queries

• We make corrections to our data when appropriate

• Our commitment to accuracy is not an operative report service
  – But we have other teams that can help you

• We take pride in having the most current:
  – Medicare fee schedule
  – NCCI edits
  – Code descriptions