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INTRODUCTION
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Introduction

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted. Section 6102 of P.L. 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, Payment for Physicians' Services. This section of the Act provided for replacing the previous reasonable charge mechanism of actual, customary, and prevailing charges with a resource-based relative value scale (RBRVS) fee schedule that began in 1992.

With the implementation of the Medicare Fee Schedule, it was increasingly important to assure that uniform payment policies and procedures were followed by all carriers so that when the same service is rendered in various carrier jurisdictions, it is paid for in the same way. In addition, accurate coding and reporting of services by physicians was a major concern to guarantee proper payment.

Most Medicare carriers have already included in their claims processing systems various computerized edits to detect improper coding of procedures. Many of these edits are designed to detect "fragmentation," or separate coding of the component parts of a procedure, instead of reporting a single code which includes the entire procedure. However, there has not been consistency or uniformity among the carriers in correct coding edits due to:

- The direction of carrier efforts because of individual carrier discretion and established priorities.

- Identification of the component parts of a comprehensive procedure because of data availability and analysis expertise.

Purpose

The purpose of the National Correct Coding Initiative=s contract is to develop, for the Health Care Financing Administration's Center for Health Plans and Providers, correct coding methodologies, to control improper coding that leads to inappropriate payment in Part B claims. In an effort to promote correct coding nationwide and assist physicians and other health care practitioners in correctly coding their services for payment, the policies developed are based on coding conventions defined in the American Medical Association's CPT manual, in national and local policies and edits, in coding guidelines developed by national societies, in analysis of standard medical and surgical practice and in review of current coding practice.

Correct Coding

There are two types of unbundling; the first is unintentional which results from a misunderstanding of coding, and the second is intentional, when this technique is used by providers to manipulate coding in order to maximize payment. Unbundling is essentially the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code.

Correct coding means reporting a group of procedures with the appropriate comprehensive code. Examples of unbundling are described below:

! Fragmenting one service into component parts and coding each component part as if it were a separate service. For example the correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate.

! Reporting separate codes for related services when one comprehensive code includes all related services. An example of this type is coding the total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries(CPT code 58150) and salpingectomy (CPT code 58700) and oophorectomy (CPT code 58940) rather than using the comprehensive CPT code 58150 for all three related services.

! Breaking out bilateral procedures when one code is appropriate. For example, a bilateral mammography is coded correctly using CPT code 76091 rather than submitting CPT code 76090-RT for right mammography and CPT code 76090-LT for left mammography incorrectly.

! Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate. A laboratory should bill CPT code 80048,(Basic metabolic panel), when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multi-channel tests. It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520 in addition to the CPT code 80048 unless one of these laboratory tests was performed at a different time of day, in which case a –91 modifier would be utilized.

! Separating a surgical approach from a major surgical service. For example, a provider should not bill CPT code 49000 for exploratory laparotomy and CPT code 44150 for total abdominal colectomy for the same operation because the exploration of the surgical field is included in the CPT code 44150.

Policy Manual Conditions & Format

The National Correct Coding Policy Manual has been developed with the following conditions applied:

- All policies and edits are formulated with the scenario of the same physician billing all of the CPT codes involved.

- The services are for the same beneficiary and provided on the same day.

It is important to recognize that the National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices than the previous ?rebundling@ program instituted by HCFA in 1992. An understanding of the general policies is necessary to understand the different types of code pair edits that are listed in the Initiative.

The Correct Coding Policy and Edits were initially based on evaluation of procedures referenced in the 1994 CPT Manual. An ongoing refinement program has been developed to address annual changes in CPT codes, either additions, deletions, or modifications of existing codes. Additionally, ongoing changes will occur based on changes in technology, in standard medical practice and from continuous input through the AMA and various specialty societies.

The manual for the National Correct Coding Policy and Edits includes a Table of Contents, 12 narrative chapters, and an index. As shown in the Table of Contents, each chapter is a separate section of the CPT Manual except Chapter I which contains general correct coding policies and Chapter XII which addresses HCPCS Level II codes under the Part B Carriers' jurisdiction. Each chapter is divided into subjects to allow easier access to a particular code or group of codes.

The intent of this manual is to provide National Correct Coding Policy and to expand the number of correct coding edits that can be adjudicated in current claims processing systems based on the limits identified by system analysis. This policy was developed for the purpose of encouraging consistent and correct coding and of controlling inappropriate payment. This activity in no way represents all possible combinations of correct coding edits or types of unbundling that exist. Further expansion of these ideas and concepts is planned for future refinement years.

If you have concerns regarding the content of this manual, please submit your comments in writing to:

National Correct Coding Initiative
AdminaStar Federal, Inc.
P.O. Box 50469
Indianapolis, IN 46250-0469