NCCI EDITS / COLONOSCOPY CODING

Fewer denials. A $35,000 annual coding opportunity.

I reviewed recurring Modifier 59 denials for a surgical practice, corrected coding and documentation practices, and identified a measurable opportunity in the claim patterns.

$35,000	$500	70
POTENTIAL ANNUAL VALUE	ESTIMATED PER CASE	CASES PER YEAR

01 / THE DENIAL PATTERN

A provider in a surgical practice was receiving denials tied to National Correct Coding Initiative (NCCI) edits. Many involved Modifier 59, which is used to identify a distinct procedural service when the circumstances and documentation support it.

02 / WHAT MY REVIEW FOUND

I found claims where a second procedure had been billed even though the record did not support reporting it separately. In other cases, the services appeared distinct, but the notes did not clearly explain why Modifier 59 applied. One example involved claims reporting 45378, diagnostic colonoscopy, alongside 45380, colonoscopy with biopsy.

THE INTERVENTION

Better coding. Better payments.

I audited the denial queue against NCCI edits, educated the practice on code selection and appropriate Modifier 59 use, and improved documentation so the record clearly supported the services billed. CMS says Modifier 59 cannot bypass an edit unless its criteria are met and the medical record supports its use.[1]

WHAT CHANGED

Denials decreased → **Allowed payments increased**

PRACTICE REPORTED OVERALL IMPROVEMENT

The practice saw an overall decrease in denials and an increase in allowed payments after the coding education and documentation improvements.

A MEASURABLE OPPORTUNITY

$500 estimated fee-schedule value per applicable case

ANNUALIZED ESTIMATE FROM THE REVIEW NOTES

70 cases / year × $500 per case = $35,000

This is a potential annual clean-revenue opportunity from correctly coded and supported claims. It is not a verified amount collected.

THE ESTIMATE

The $35,000 calculation uses the notes' estimate of 70 applicable cases per year at about $500 per case. Actual payment depends on the services performed, documentation, payer rules, and claim adjudication. The practice reported an overall improvement, but no denial-rate or collection figures were provided.

The practice name and provider details are omitted to protect identity. [1] CMS, Modifier 59 guidance and NCCI edits.