National Correct Coding Initiative (NCCI)

In 1996, the Centers for Medicare and Medicaid Services (CMS) developed the Medicare National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to monitor for incorrect payments. The policy was based on coding conventions defined in the American Medical Association’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies and analysis of standard medical and surgical practices. It is updated quarterly and found on the CMS website at the following link: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed code pair tables that indicate HCPCS/CPT codes that should not be reported together for Part B services. There are separate tables for outpatient facility claims and physician claims. Code pairs are listed in Column 1 and Column 2 of the table. CMS will pay the code in Column 1 and deny payment for the code in Column 2 unless an appropriate modifier is present as listed in the Modifier column. These denials are referred to as CCI Edits and are automatically denied upon adjudication of the claim. The NCCI methodology has been adopted by most health insurance companies with slight differences as defined by each company’s payment rules.

Example of Code Pair Table:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>*= In Existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>22612 Arthrodesis Single Lumbar</td>
<td>22830 Exploration of Surgical Field</td>
<td>*=No Data</td>
<td>19960101</td>
<td>*</td>
<td>1</td>
</tr>
</tbody>
</table>

Codes denied in Column 2 of the code pair table include those that are inclusive of a more comprehensive code or are mutually exclusive. A mutually exclusive code is one that could not be performed at the same encounter because their similarity cancels the other out i.e., a repair of an organ by two different methods. Only one method can be reported at the same encounter.

In the above example, the exploration of a surgical field is not separately payable for an arthrodesis unless it is performed on a separate anatomical area of the spine. This claim would automatically deny due to CCI edits. A provider would need show support of the separate procedure in the medical record and append the appropriate modifier to the claim.

In addition to the NCCI tables, CMS provides an NCCI Policy Manual for Medicare Services. It can be found using the link listed above. The policy manual provides detail about appropriate coding practices. Below is an excerpt from the chapter related to HCPCS/CPT codes in the range 20000-29999:

“9. Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code
22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59.”

Medically Unlikely Edits (MUEs)

In addition to the NCCI edits, CMS developed a list of Medically Unlikely Edits (MUEs) and Add-on Code Edits. This information is found at the link above.

Medically Unlikely Edits (MUEs) were established in January 2007. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service. All HCPCS/CPT codes do not have an MUE. CMS publishes most MUE values but some values are confidential. It is updated quarterly and there are separate tables for Physicians, Facilities and DME.

The MUE table includes the HCPCS/CPT Code, the number of maximum units, a MUE Adjudication Indicator and MUE Rationale. In July 2014, CMS added the MUE Adjudication Indicator and MUE Rationale and changed many of the MUEs into a per day edit vs. a line item edit. This is due to findings of overcharging units for bilateral procedures by the Office of Inspector General (OIG). See MLN Matters SE1422 for more information.

An example of a MUE error: Physician billed 200 units of J7665 + Mannitol, administered through an inhaler, 5mg. The MUE table limits the quantity to 127. It is important when billing injectable medication to convert the number of units per the dosage requirements. The correct number of units billed is 40 (200mg/5mg). This claim line would be rejected for an MUE error.

Add-on Code Edits

Add-on Code Edits is a list of codes that must be reported with the appropriate primary procedure code performed on the same encounter for a patient. Add-on codes billed without the primary code will be denied for payment. If the primary procedure is not payable, the Add-on code is not payable. CMS has three categories of Add-on code edits:
Type 1 + Add-on code is linked to one or more primary procedure codes and is payable if the primary procedure code is paid.
Type 2 + Add-on code is not linked to a primary procedure code. Payment is defined by the Medicare Administrative Contractor.
Type 3 + Add-on code has some primary procedure codes linked to it and others that are not linked and are defined by the Medicare Administrative Contractor.

Total Health Care’s claims adjudication system incorporates the NCCI, MUE and Add-on Code edits established by CMS.