

INTRODUCTION  
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INTRODUCTION  
FOR  
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES

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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 Physician Fee Schedule (PFS), it was important to assure that uniform payment policies and procedures were followed by all Medicare Administrative Contractors (MACs) so that the same service would be paid similarly in all (A/B MAC processing practitioner service claims) jurisdictions. Accurate coding and reporting of services by physicians is a critical aspect of assuring proper payment.

## **Purpose**

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) **program** to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT) Manual," national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

**The** NCCI **program** includes 3 types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code (AOC) Edits.

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.

MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is

the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service. Additional general information concerning NCCI PTP edits and MUEs is discussed in Chapter I.

AOC edits consist of a listing of HCPCS and CPT Add-on Codes with their respective primary codes. An Add-on Code is eligible for payment if and only if one of its primary codes is also eligible for payment.

NCCI PTP edits are used by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI **program** was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries (FIs) (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Carriers and FIs are now designated by **the** CMS as A/B MACs. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in **the** NCCI **program**. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims (FIs) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits used for practitioner claims are also used for Ambulatory Surgical Center (ASC) claims.

Prior to January 1, 2012, NCCI PTP edits incorporated into OCE appeared in OCE 1 calendar quarter after they appear in **the** NCCI **program**. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. Physicians, hospitals, and other providers must code correctly even in the absence of NCCI or OCE edits. For example, new Category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in **the** NCCI **program** on January 1. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April

1. Hospitals were required to code correctly during the three-month delay.

On January 1, 2007, the CMS incorporated MUEs into the NCCI program. These edits are applicable to claims submitted to Carriers (A/B MACs processing practitioner service claims), A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and FIs (A/B MACs processing outpatient hospital service claims).

Pursuant to Section 6507 of the Patient Protection Affordable Care Act (PPACA), the CMS provided instructions to States for implementation of NCCI methodologies in State Medicaid programs by October 1, 2010. The CMS publishes on its website separate edit files and manuals for the CMS State Medicaid NCCI program methodology. In order to avoid confusion between the use of the term NCCI for the NCCI program methodology and NCCI PTP edits, the CMS Medicare and Medicaid NCCI programs use the term NCCI PTP to identify NCCI Column One/Column Two edits. The Medicaid NCCI methodology edit files contain edits for HCPCS CPT codes used in the Medicaid program and the Medicare NCCI edit files contain NCCI PTP and MUE edits that are used in the Medicare program.

In this Manual many policies are described utilizing the term "physician." Unless indicated differently the use of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

Providers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare "Internet-only Manual (IOM)" instructions.

CPT codes representing services denied based on NCCI PTP edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot use an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary.

Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, the NCCI program policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

NCCI PTP edits are adopted after due consideration of Medicare policies including the principles described in the National Correct Coding Initiative Policy Manual for Medicare Services, HCPCS and CPT Manual code descriptors, CPT Manual coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider billing patterns. Since the NCCI program is developed by the CMS for the Medicare program, the most important consideration is CMS policy.

Prior to initial implementation of the NCCI program in 1996, the proposed edits were evaluated by Medicare Part B Carrier Medical Directors, representatives of the AMA CPT Advisory Committee, and representatives of other national medical and surgical societies.

The NCCI program undergoes continuous refinement with revised edit tables published quarterly. There is a process to address annual changes (additions, deletions, and modifications) of HCPCS/CPT codes and CPT Manual coding guidelines. Other sources of refinement are initiatives by the CMS central office and comments from the CMS regional offices, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers, consultants, other third-party payors, and other interested parties. Prior to implementing new edits, the CMS generally provides a review and comment period to representative national organizations that may be impacted by the edits. However, there are situations when the CMS thinks that it is prudent to implement edits prior to completion of the review and comment period. The CMS Central Office evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

### **Policy Manual Background**

The "National Correct Coding Initiative Policy Manual for Medicare Services," NCCI PTP edits, MUEs, and AOC edits have been developed for application to Medicare services billed by a single provider for a single patient on the same date of service.

The "National Correct Coding Initiative Policy Manual for

Medicare Services" and the edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a provider determines that they have been coding incorrectly, the provider should contact their MAC about potential payment adjustments.

The "National Correct Coding Initiative Policy Manual for Medicare Services" and edits were initially based on evaluation of procedures referenced in the 1994 CPT Manual and HCPCS Level II codes. An ongoing refinement program has been developed to address annual changes in CPT codes and instructions, additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes occur based on changes in technology, standard medical practice, and input from the AMA, specialty societies, other national healthcare organizations (NHOs), Medicare contractor medical directors and staff, providers, consultants, etc.

The "National Correct Coding Initiative Policy Manual for Medicare Services" includes a Table of Contents, an Introduction, and 13 narrative chapters. As shown in the Table of Contents, each chapter corresponds to a separate section of the CPT Manual except Chapter I which contains general correct coding policies, Chapter XII which addresses HCPCS Level II codes, and Chapter XIII which addresses Category III CPT codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

The "National Correct Coding Initiative Policy Manual for Medicare Services" in general uses paraphrased descriptions of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's "Current Procedural Terminology (CPT) Manual" and **the** CMS' HCPCS Level II code descriptors for complete descriptors of the codes.

### **Edit Development and Review Process**

The NCCI **program** undergoes constant refinement, publishing 4 versions annually. Medicare Administrative Contractors (MACs) implement the versions effective January 1, April 1, July 1, and October 1 of each year. Changes in **the** NCCI **program** come from 3 sources: (1) additions, deletions, or modifications to CPT or HCPCS Level II codes or CPT Manual instructions; (2) CMS policy

initiatives; and (3) comments from the AMA, national or local medical/surgical societies, other NHOs, Medicare contractor medical directors and staff, providers, billing consultants, etc.

The CMS sends proposed changes in the NCCI edits to the AMA, national medical/surgical societies, and other NHOs who participate in a review and comment period. The CMS may also specifically seek comment from national medical/surgical societies, providers, and other NHOs before implementing many types of changes in the NCCI program.

Although national medical/surgical societies and other NHOs generally agree with changes the CMS makes to the NCCI program, the CMS carefully considers all comments. When the CMS decides to proceed with changes in the NCCI program contrary to the comments of national medical/surgical societies or other NHOs, it does so after due consideration of those comments and other information available to the CMS.

An NCCI edit is applicable to the time period for which the edit is effective since the edit is based on coding instructions and practices in place during the edit's effective dates. NCCI PTP, MUE, or AOC edits may be revised for a variety of reasons. Edit revisions may be effective in the next version of the relevant edit file or may be retroactive. A change in an NCCI edit is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive change, Medicare Administrative Contractors (MACs) are not expected to identify claims but may reopen impacted claims that would have payment changes that providers/suppliers bring to their attention. In accordance with CMS policy, MACs may reopen impacted claims with potential payment changes brought to their attention by provider/suppliers. Since NCCI edits are auto-deny edits, denials may be appealed. Appeals shall be submitted to MACs, not the NCCI contractor. MACs adjudicating an appeal for a claim denial for a CPT/HCPCS code with an MUE and an MUE Adjudication Indicator (MAI) of "1" or "3" may pay correctly coded and correctly counted medically necessary UOS in excess of the MUE value. In limited circumstances, the CMS may at times issue directions for a mass adjustment when it determines that such an action meets the needs of the program and can occur within its current operational constraints.



## Sources of Information about NCCI and MUE

The CMS website contains:

- 1) National Correct Coding Initiative Policy Manual for Medicare Services ([Current Version](#) and [Archived Manuals](#));
- 2) NCCI [PTP edits](#) used for practitioner claims;
- 3) NCCI [PTP edits](#) used for outpatient hospital claims in the Outpatient Code Editor (OCE);
- 4) NCCI and MUE [Frequently Asked Questions \(FAQ\)](#);
- 5) [MUE](#) Overview;
- 6) HCPCS/CPT codes with published MUE values in the Practitioner Services [MUE table](#);
- 7) HCPCS/CPT codes with published MUE values in the Facility/Hospital Outpatient Services [MUE table](#);
- 8) HCPCS/CPT codes with published MUE values in the Durable Medical Equipment (DME) Supplier Services [MUE table](#);
- 9) Current [quarterly version update changes](#) for NCCI PTP edits and published MUEs;
- 10) [AOC edits](#) used for practitioner claims;
- 11) Current quarterly updates to [Add-on Code Edits](#); and
- 12) Medicare Learning Network Publication: "[How to Use the National Correct Coding Initiative \(NCCI\) Tools](#)"

## Correspondence to CMS about NCCI and its Contents

The NCCI **program** is maintained for **the** CMS by a contractor. If the user of this manual has concerns regarding the content of the edits or this manual, the user may send an inquiry in writing to the CMS NCCI PTP/MUE email address or address identified on the [CMS NCCI webpage](#).

**The** CMS makes all decisions about the contents of **the** NCCI **program** and this manual. Correspondence from the NCCI contractor reflects CMS's policies on **correct** coding and **the** NCCI **program**.