**INTRO.doc**
**Version 15.3**

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

***Current Procedural Terminology*** **© 2008 American Medical Association. All Rights Reserved.**

***Current Procedural Terminology*** **(CPT) is copyright 2008 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.**

***CPT®*** **is a trademark of the American Medical Association.**

## 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, it was important to assure that uniform payment policies and procedures were followed by all carriers (A/B MACs processing practitioner service claims) so that the same service would be paid similarly in all carrier (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 and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) 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.

Although the NCCI 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 (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims paid by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) were also subject to NCCI edits in the OCE.

NCCI edits incorporated into OCE appear in OCE one calendar quarter after they appear in NCCI. Hospitals like physicians 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 NCCI on January 1. However, the new edits for these codes do not appear in OCE until the following April 1. Hospitals must code correctly during the three month delay.

On January 1, 2007, CMS incorporated Medically Unlikely Edits (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 Fiscal Intermediaries (FIs) A/B MACs processing outpatient hospital service claims).

In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage 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.

CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an “Advanced Beneficiary Notice” (ABN) form to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a “Notice of Exclusions from Medicare Benefits” (NEMB) form.

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

**Policy Manual Background**

The *National Correct Coding Initiative Policy Manual for Medicare Services* and NCCI 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 replaced and is more comprehensive than the “rebundling” program instituted by CMS, formerly HCFA, in 1991.

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 he/she has been coding incorrectly, the provider should contact his/her Carrier, Fiscal Intermediary, or 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, 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 utilizes 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 CMS's HCPCS Level II code descriptors for complete descriptors of the codes.

**Edit Development and Review Process**

The NCCI undergoes constant refinement publishing four versions annually. Medicare Carriers (A/B MACs processing practitioner service claims) implement the versions effective January 1, April 1, July 1, and October 1. Medicare Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) also implement four annual versions of NCCI in OCE on January 1, April 1, July 1, and October 1. Changes appearing in the NCCI edits for Medicare Carriers (A/B MACs processing practitioner service claims) appear in OCE one quarter later. Changes in NCCI come from three 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 national healthcare organizations, Medicare contractor medical directors and staff, providers, billing consultants, etc.

CMS notifies the AMA and national medical/surgical societies of the quarterly changes in NCCI. Additionally, CMS seeks comment from national medical/surgical societies and other national healthcare organizations before implementing many types of changes in NCCI. Although national medical/surgical societies and other national healthcare organizations generally agree with changes CMS makes to NCCI, CMS carefully considers those adverse comments received. When CMS decides to proceed with changes in NCCI contrary to the comments of national medical/surgical societies or other national healthcare organizations, it does so after due consideration of those comments and other information available to CMS.

**Correct Coding**

Physicians must report services correctly. This manual discusses general coding principles in Chapter I and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. Although the emphasis in the manual is correct coding, there are certain types of improper coding that physicians must avoid.

Procedures should be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician should not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

- A physician should not fragment a procedure into component parts. For example, if a physician performs an upper gastrointestinal endoscopy with biopsy of the stomach, the physician should report CPT code 43239 (Upper gastrointestinal endoscopy...; with biopsy,...). It is improper to unbundle this procedure and report CPT code 43235 (Upper gastrointestinal endoscopy...; diagnostic,...) plus CPT code 43600 (Biopsy of stomach;...). The latter code is not intended to be utilized with an endoscopic procedure code.

- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example if a physician performs bilateral mammography, the physician should report CPT code 77056 (Mammography; bilateral). The physician should not report CPT code 77055 (Mammography; unilateral) with two units of service or 77055LT plus 77055RT.

- A physician should not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician should not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes

describing the services not included in the less comprehensive code. For example if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider should report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician should not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must avoid upcoding. A HCPCS/CPT code may be reported only if all services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the physician should not report CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criteria that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician should not report a "per session" code using fifteen minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

**Sources of Information about NCCI and MUE**

The CMS website contains:

1) *National Correct Coding Initiative Policy Manual for Medicare Services* (http://www.cms.hhs.gov/NationalCorrectCodInitEd/);
2) NCCI edits utilized for practitioner claims (http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/);
3) NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/);
4) NCCI Frequently Asked Questions (FAQ) (http://www.cms.hhs.gov/NationalCorrectCodInitEd/);
5) MUE Overview (http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage);

6) MUE Frequently Asked Questions (FAQ) (http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage);
7) HCPCS/CPT codes with published MUE values in the Practitioner/DME Supplier MUE table (http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage);
8) HCPCS/CPT codes with published MUE values in the Hospital Outpatient Services MUE table (http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage); and
9) Medicare Learning Network Publication: "Medicare Claim Review Programs: MUE, CCI, CERT, RAC" (http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1209400&intNumPerPage=10)

Sources of information about NCCI published by entities other than CMS or its NCCI contractor should not be relied upon for guidance about the NCCI or MUE in legal matters regarding the Medicare program.

**Correspondence to CMS about NCCI and its Contents**

The NCCI is maintained for CMS by Correct Coding Solutions, LLC. If the user of this manual has concerns regarding the content of the edits or this manual, an inquiry may be submitted in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax number: (317) 571-1745

CMS makes all decisions about the contents of NCCI and this manual. Correspondence from Correct Coding Solutions, LLC reflects CMS's policies on coding and NCCI.