



News Flash – Are you ready for the new Medicare provider authentication process at Fiscal Intermediaries (FIs), Carriers, or Medicare Administrative Contractors (MACs)? Effective April 6, 2009, for all Medicare provider telephone and written inquiries to your Medicare claims processing contractors, inquirers will need to give the last five digits of the provider's tax identification number (TIN) in addition to the provider's national provider identifier (NPI) and provider transaction access number (PTAN). In addition, inquirers will only be allowed three attempts to provide the correct NPI, PTAN, and last five digits of the TIN. You can find more information about the new provider authentication requirements for Medicare inquiries to your Medicare claims processing contractors by going to the MLN Matters article related to CR 6139, located at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6139.pdf> on the CMS website.

MLN Matters Number: MM6388

Related Change Request (CR) #: 6388

Related CR Release Date: March 13, 2009

Effective Date: April 1, 2009

Related CR Transmittal #: R1699CP

Implementation Date: April 6, 2009

Note: This article was updated on December 17, 2012, to reflect current Web addresses. All other information remains unchanged.

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 15.1, Effective April 1, 2009

Provider Types Affected

Physicians submitting claims to Medicare Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6388, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2009.

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Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and
- Review of current coding practice.

The latest package of CCI edits, Version 15.1, is effective April 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

- Column 1/ Column 2 Correct Coding Edits, and
- Mutually Exclusive Code (MEC) Edits.

Additional information about CCI, including the current CCI and MEC edits, is available at

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the CMS website.

Additional Information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf> on the CMS website.

The official instruction (CR 6388) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1699CP.pdf> on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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