INTRODUCTION
FOR
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

Revision Date (Medicare): 1/1/2025

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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) jurisdictions. Accurate coding and reporting of services are critical aspects 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) Professional* codebook, 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 Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code. If a provider/supplier 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 allowed and 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) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier 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 AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

NCCI PTP edits are used by Medicare claims processing contractors to adjudicate provider/supplier claims for practitioner services, outpatient hospital services, outpatient therapy services, and others listed in the How to Use NCCI Tools booklet. They are not applied to facility claims for inpatient services.

NCCI Program Background

Although the NCCI program was initially developed for use by Medicare Carriers (A/B MACs) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by MACs 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 the NCCI program. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims 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.

On January 1, 2007, the CMS incorporated MUEs into the NCCI program. These edits are applicable to claims submitted to A/B MACs, Durable Medical Equipment (DME) MACs.

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. Outpatient hospitals and other providers/suppliers 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.

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. 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 using 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/supplier 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.

CMS implements NCCI PTP edits after due consideration of Medicare policies including the principles described in the *Medicare NCCI Policy Manual*, HCPCS and *CPT Professional* codebook code descriptors, *CPT Professional* codebook coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider/supplier 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 Professional* codebook coding guidelines. Other sources of refinement are initiatives by CMS and comments from CMS, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers/suppliers, 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. CMS evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

Policy Manual Background

CMS developed the *Medicare NCCI Policy Manual*, NCCI PTP edits, MUEs, and AOC edits for application to Medicare services billed by a single provider/supplier for a single patient on the same date of service.

CMS developed the *Medicare NCCI Policy Manual* and the edits to encourage consistent and correct coding and reduce inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers/suppliers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a provider/supplier determines that they have been coding incorrectly, the provider/supplier should contact their MAC about potential payment adjustments.

The *Medicare NCCI Policy Manual* and edits were initially based on evaluation of procedures referenced in the 1994 *CPT Professional* codebook 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/suppliers, consultants, etc.

The *Medicare NCCI Policy Manual* 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 Professional* codebook 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 *Medicare NCCI Policy Manual*, in general, uses paraphrased descriptors of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's *CPT Professional* codebook and the CMS's 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. 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 Professional* codebook 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/suppliers, 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/suppliers, 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.

A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of a PTP edit, an MUE value, or an AOC edit for a HCPCS/CPT code by submitting a written request to: NCCIPTPMUE@cms.hhs.gov. The written request should include a rationale for reconsideration, as well as a suggestion. Any submissions made to the NCCI contractor that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically discarded, regardless of the content, in accordance with federal privacy rules with which the NCCI Contractor must comply.

The CMS implements edit revisions as soon as technically possible, and they 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, MACs are not expected to identify claims but may reopen impacted claims that would have payment changes that providers/supplier 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.

The NCCI webpages contain information about the NCCI program including the following.

1. Medicare NCCI
    a. *Medicare NCCI Policy Manual* (Current Version and Archived Manuals)
    b. Medicare Correspondence Language Manual
    c. Medicare Add-on Code Edits
    d. Medicare Frequently Asked Question (FAQ) Library
    e. Medicare Medically Unlikely Edit Archive
    f. Medicare Medically Unlikely Edits
    g. Medicare Procedure to Procedure Edits
    h. Helpful Educational Materials e.g., How to Use Medicare NCCI Tools
2. Medicaid NCCI
    a. Medicaid Correspondence Language Manual
    b. Medicaid Edit Files
    c. Medicaid Frequently Asked Question (FAQ) Library

d. Medicaid MUE Archive
e. *Medicaid NCCI Policy Manual* (Current Version and Archived Manuals)
f. Medicaid Technical Guidance Manual
g. Helpful Educational Materials e.g. How to Use the Medicaid NCCI Tools

Correspondence with CMS about the Medicare NCCI Program and its Contents

The NCCI program cannot answer questions outside of our scope, or questions about other CMS programs or about other payors. For example, we cannot answer questions about Local Coverage Determinations, changes to code descriptors or status indicators, or modifiers not associated with NCCI.

The Medicare NCCI webpages include edit files, FAQs, and additional information. CMS does not provide a look-up service or a clean claims tool.

A provider, health care organization, or other interested party may request reconsideration of an NCCI PTP edit, an AOC edit, or an MUE value. A written request should include the rationale for the proposed change. For a PTP edit, specify the Column One and Column Two code pair(s). For an AOC edit, specify the AOC and the primary code(s). For an MUE, suggest an alternative MUE value. All written requests should specify the NCCI program (i.e., Medicare or Medicaid) and the edit type (i.e., Practitioner/Ambulatory Surgical Center, Outpatient Hospital Facility, or Durable Medical Equipment).

****NOTE**** Don't submit any Personally Identifiable Information (PII) or Protected Health Information (PHI).

The NCCI program may address general questions and concerns about the NCCI program and edits. You must submit claim-specific inquiries to the MAC. This includes appeals of NCCI-related denials; see Submitting an Appeal below.

The NCCI contractor maintains the Medicare NCCI program for CMS. If you have comments about the edits or this manual, you may send an inquiry in writing to NCCIPTPMUE@cms.hhs.gov.

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

Submitting an Appeal

You must submit appeals to your responsible MAC or QIC, not the NCCI Contractor. To file an appeal, please follow the instructions on the Appeals website. The NCCI contractor cannot process specific claim appeals and cannot forward appeal submissions to the appropriate appeals contractor.

Other Payors

The NCCI program provides general information to the public regarding the NCCI program and edits. However, we do not provide specific billing or coding advice to providers/suppliers. Questions regarding specific claims (e.g., specific scenarios) should be addressed to your payor.

If the issue you are having applies to other government, third-party, or private insurers who voluntarily choose to implement NCCI edits, we do not have control over how those edits are applied outside of Medicare. If you have questions about other plans, please contact your payer. If you have questions or concerns regarding specific Medicare claims, please contact your local Medicare Administrative Contractor (MAC).