Correct Coding Initiative: National

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This section provides information about how the National Correct Coding Initiative (NCCI) may impact claims submitted by Medi-Cal providers to the Department of Health Care Services Fiscal Intermediary.

National Correct Coding Initiative

‹‹The NCCI program was originally developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and to prevent Medicare Part B overpayments of improperly coded services.

The CMS developed its coding polices based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual, national Medicare policies, coding guidelines developed by national societies, standard medical and surgical practices, and review of current coding practices.

Adoption of NCCI for Medicaid

After the initiative showed cost savings for Medicare, the federal Patient Protection and Affordable Care Act (H.R. 3590, Section 6507) was passed. The Act required state Medicaid programs, like Medi-Cal, to incorporate NCCI edits into their claims processing systems.

The CMS adopted the contents of the NCCI Policy Manual for Medicare Services with modifications for state Medicaid programs.

It is important to note that Medicaid NCCI guidelines differ from Medicare NCCI guidelines.››

NCCI Information: Websites

‹‹The CMS website is the official location for NCCI information.

The NCCI web page on the Medi-Cal Provider website contains the following:

- Medicare and Medicaid NCCI Overviews
- Links to helpful tools on the CMS Medicaid NCCI website››
- Recently published NCCI-related Medi-Cal articles
- Other information helpful to understanding how NCCI impacts Medi-Cal

‹‹Types of NCCI Claim Edits

NCCI edits are designed to control incorrect coding combinations or unlikely excessive services reported on claims with CPT and HCPCS codes.

The NCCI edits are based on claims with the same date of service, same provider and same recipient.

The CMS updates NCCI edits for each calendar quarter and are effective for claims received on or after the first day of the new quarter.

There are two types of NCCI claim edits:

- Procedure-to-procedure edits (PTP)
- Medically Unlikely Edits (MUEs)

Procedure-to-Procedure Edits

PTP edits define pairs of procedure codes that should not be reported together under most circumstances.

Each edit has a “Column One” and “Column Two” for HCPCS and/or CPT codes. If a provider reports the two codes in an edit pair on a claim or on separate claims, the Column Two code is denied and the Column One code is eligible for payment.

- *Comprehensive vs. Component*: The code in Column One, which usually represents the more significant (comprehensive) procedure, is compared to the code in Column Two, which is considered a subpart (component) of the service in Column One.
- *Mutually Exclusive*: The code in Column One is compared to the code in Column Two because it is unlikely that both services would be rendered to the same recipient, by the same provider, on the same date of service.

The CMS Medicaid Complete Edit files for PTP edits are available to the public to use as a tool to identify when a code is considered the Column One or Column Two code of a PTP edit pair.

These files have an additional function to indicate when the use of an NCCI-associated modifier is allowed in order to bypass the edit. If the Modifier Indicator listed for the Column One/Column Two pair is “0”, the PTP edit will not be bypassed even if an NCCI-associated modifier is appended to one of the codes. If the modifier indicator listed for the Column One/Column Two pair is “1”, an NCCI-associated modifier may be appended to a HCPCS/CPT code only if the clinical circumstances justify the use of the modifier. Refer to the *Modifiers* section below for further information.››

‹‹Medically Unlikely Edits

Medically Unlikely Edits (MUE) prevent payment for an inappropriate number/quantity of the same service billed on a single day. These edits are applied per each claim line.››

Modifiers

‹‹Modifiers Associated with PTP Edits

CMS has identified a set of national modifiers to facilitate NCCI PTP claims processing. Providers may use the following modifiers to accurately define service encounters:››

Anatomical Modifiers: E1 thru E4, FA, F1 thru F9, LC, LD, LM, LT, RC, RI, RT, TA, T1 thru T9

‹‹Global Surgery Modifiers: 24, 25, 57, 58, 78, 79

Other Modifiers: 27, 59, 91, XE, XP, XS, XU››

Modifier Guidelines

Important rules for entering NCCI-associated modifiers on claims include the following:

- ‹‹Medi-Cal allows up to four modifiers on a single claim line for both the *CMS-1500 and UB-04* claim forms.››
- Modifiers must not be billed in the first modifier position on the claim (right next to the procedure code) unless it is the only modifier on that claim line.
- Modifiers may be entered on the same claim line as other national modifiers that are not NCCI associated.
- Modifiers must appear after modifier 99 (multiple modifiers) when billed on the same claim line.
- Modifiers must meet all CMS and Medi-Cal conditions for use of that modifier.
- ‹‹Providers must bill NCCI-associated modifiers as directed on the CMS website.
- If both codes in an NCCI PTP pair use the same NCCI-associated anatomical modifiers to provide additional information about services provided, one of the codes must also include one of the following NCCI-associated modifiers: 58, 59, 78, 79, XE, XP, XS or XU only if the use of one of these modifiers justify appropriate clinical circumstances.
- Documentation in the medical record must meet the criteria required by any NCCI-associated modifier that is used.››

Claims are subject to post-payment audits and may be reviewed to ensure the preceding items are accurate.

‹‹Modifiers Associated with MUEs››

Modifier 55: Post-Operative Management

CMS mandates that MUEs are not to be applied to claims submitted for any procedure code billed with modifier 55 (post-operative management only). Modifier 55 is not an official NCCI-associated modifier and will not be identified as such in the *Modifiers: Approved List* section. Instead, the CMS mandate establishes a special processing guideline for claims submitted with any procedure code and modifier 55.

Orthotics and Prosthetics

For instructions to appropriately bill bilateral orthotics and prosthetic (O&P) appliances, refer to “Bilateral Appliances” in the *Orthotic and Prosthetic Appliances and Services* section in the appropriate Part 2 manual.

Services Affected

NCCI edits are not applied to all Medi-Cal claims and services. Only the following are subject to NCCI edits:

- Practitioner services
- Ambulatory Surgical Center (ASC) services
- Outpatient Hospital services
- Supplier claims for Durable Medical Equipment (DME)

Authorization and Documentation

Medi-Cal services that required authorization as a *Treatment Authorization Request* (TAR) or *Service Authorization Request* (SAR), and/or medical documentation before NCCI implementation will continue to require the same authorization and/or medical documentation. In some circumstances, depending on the type of NCCI edit, the TAR/SAR or medical documentation may be allowable justification to bypass an NCCI edit.

Claims Processing

NCCI PTP and MUE edits are applied to services performed by the same provider for the same recipient on the same date of service. PTP edits are applied to all services with the same date of service whether the services are submitted on the same or different claims. MUE edits are applied separately to each line of a claim.

ZIP (compressed) files that include lists showing NCCI PTP and MUE edits are available on the NCCI in Medicaid website. Beginning in 2011 edits related to HCPCS Level II codes have been listed in the back of the HCPCS manual.

Newborns/Multiple Births Using the Mother's Identification Number

Services rendered to an infant (or infants in a multiple birth scenario, such as twins) may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant(s) must have their own Medi-Cal ID number.

If a provider performs the same service for a newborn and the mother, on the same date of service, or the provider is billing the same service provided for newborns in a multiple birth scenario, on the same date of service, the provider must enter the newborn recipient's information as follows in order to bypass any potential NCCI edit:

Newborns Claim Completion Instructions Table

Claim Field	Instructions	*CMS-1500**	*UB-04**
Insured ID number	‹‹Mother's Medi-Cal ID Number as it appears on the Benefits Identification Card (BIC) or Medi-Cal Eligibility Confirmation Letter››	Box 1A	Box 60
Patient name	If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Each baby from a multiple birth must also be designated by a number or letter (example: Jones Baby Girl Twin A).	Box 2	Box 8B
Date of birth	Infant's date of birth	Box 3	Box 10
Sex	Infant's sex	Box 3	Box 11
Insured's Name	Mother's name	Box 4	Box 58
Patient's Relationship to Insured	*CMS 1500* - Check the Child box *UB-04* - Enter "03" (child)	Box 6	Box 59

‹‹**Newborns Claim Completion Instructions Table (continued)**››

Claim Field	Instructions	***CMS-1500****	***UB-04****
Additional Claim Information/Remarks	Enter “Newborn Infant Using Mothers ID” or “Newborn Using Mother’s ID (Twin A) or (Twin B)	Box 19	Box 80
Patient’s Account Number/Patient control number	Optional field that will help providers identify a recipient on Remittance Advice Details (RAD)	Box 26	Box 3A

On the *CMS-1500*, if the same doctor who delivers the baby or babies also examines the baby or babies, the same NPI used for the mother is entered in the *Billing Provider Info & Phone #* field (Box 33).

Note: The nine-digit ZIP code entered in this box must match the billing provider’s nine-digit ZIP code on file for claims to be reimbursed correctly

Claim Denial and Appeal

Claims that fail the NCCI Medicaid edits will be denied and returned to the provider, who may submit an appeal for reconsideration of payment.

Note: *Claims Inquiry Forms* (CIFs) must not be submitted for reconsideration of claims denied as a result of NCCI edits.

The appeal process for claims denied due to NCCI edits is the same as the appeal process for claims denied due to standard Medi-Cal edits. See the Part 2 *Appeal Form Completion* section.

Appeals: Understanding the Modifier Indicator

The Column One/Column Two table modifier indicator (0, 1 or 9) is helpful in understanding whether to appeal. Code combinations on the table with a modifier indicator of “0” require the ruling of an administrative law judge to be paid. Code combinations with a modifier indicator of “1” are more commonly appealed. The appeal must document the following:

- Services were medically necessary.
- An appropriate NCCI-associated modifier could have been used on the initial claim.
- Use of the NCCI-associated modifier would have caused the column 2 code to pass the NCCI edit.

Appealing MUE Denials

Appeals submitted to override an MUE edit and pay units of service in excess of the MUE must include proof that the services were medically reasonable and necessary, the correct HCPCS or CPT code was reported and the units of service were counted correctly. If the appeal officer determines that all reported MUEs were not applicable, the appeal officer may pay the units of service that were applicable.

For additional information, providers may refer to “NCCI Appeals,” located on the CMS website.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
‹‹*	Most claims can also be submitted through an 837 claim. For 837 claims registration information, refer to the *Electronic Data Interchange (EDI) 837 Claims Overview* section in the Part 1 manual.››