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 National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to prevent Medicare overpayments of improperly coded services. 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.

NCCI edits are designed to control incorrect coding combinations or unlikely excessive services reported on claims with CPT® and HCPCS Level II codes. CMS updates NCCI edits quarterly.

There are two types of NCCI claim edits:

- Procedure-to-procedure (column 1/column 2) edits: These edits define pairs of HCPCS and CPT codes that should not be reported together. The purpose of these edits is to ensure the most comprehensive groups of codes are billed, rather than the component parts. Additionally these edits check for mutually exclusive code pairs.
- Medically Unlikely Edits (MUEs): These edits compare the units of service billed on the claim against maximum limits set by CMS for selected HCPCS or CPT codes. For example, a provider will not be reimbursed for removing more than one gall bladder or appendix.

NCCI Information: Websites

The Centers for Medicare & Medicaid website (*www.cms.gov*) is the official location for NCCI information.

However, an NCCI area has been created on the Medi-Cal Provider website at *http://files.medi-cal.ca.gov/pubsdoco/ncci/ncci.aspx*. This area contains the following:

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

CMS Tools for Providers

CMS has the following tools available for Medicaid providers:

- The *National Correct Coding Initiative Policy Manual for* Medicaid Services manual to help providers, medical review and appeals staff understand the policies upon which CMS bases the NCCI and MUE edits.
- The ZIP (compressed) files that detail NCCI and MUE edits.
- The *NCCI Correspondence Language Manual*. Each NCCI edit and MUE has a correspondence language example identification (CLEID) number. This manual matches CLEID numbers with correspondence related to each edit's policy rationale.

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 services
- Outpatient hospital services
- Supplier claims for Durable Medical Equipment

Authorization and Documentation

Medi-Cal services that required authorization (*Treatment Authorization Request* or Service Authorization Request) 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.

NCCI Column 1/Column 2

CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The results of that analysis helped define the CMS editing tables, which are being incorporated into Medi-Cal's claims processing system.

‹‹**Correct Coding Edit Table**››

Column 1 Code	Column 2 Code	Modifier Use
12001	64450	Not allowed
12001	G0168	Allowed
12001	93010	Allowed

The column 1/column 2 correct coding edit table contains two types of code pair edits, as follows:

Comprehensive: The code in column 1, 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 1. Claims submitted for reimbursement of both codes without justification will be denied because the service represented by the code in column 1 includes the service represented by the code in column 2.

Mutually Exclusive: The code in column 1 is compared to the code in column 2. The claim is denied because it is unlikely that both services would be rendered to the same recipient, by the same provider on the same date of service (for example, a hysterectomy and vasectomy).

The column 1/column 2 table has an additional function, to indicate when the use of an NCCI-associated modifier is allowed in order to bypass the edit. When a modifier is allowed, by the indicator of "1", providers may use an applicable modifier to show their claim is an exception to usual practices. For example, a physician performing two identical Evaluation and Management (E&M) services on twins with the same Medi-Cal number in the first 60 days of life might enter modifier 25 on the claim and provide documentation showing that the two E&M services were significant and separately identifiable procedures.

Modifiers

CMS has identified a set of national modifiers to facilitate NCCI claims processing. For claims where multiple encounters or other circumstances could appear to fail NCCI edits and lead to inappropriate claim denial, providers may use the following modifiers to accurately define service encounters.

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

Other Modifiers: 24, 27, 57, 59, 91

Global Surgery Modifiers: 25, 58, 78, 79

Medi-Cal allows up to four modifiers on a single claim line for both the *CMS-1500* and *UB-04* claim forms.

Modifier Guidelines

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

- Only one modifier used for the purpose of bypassing an NCCI-edit may be entered on a single claim line. Claims submitted with more than one NCCI-associated modifier (see chart above) on the same claim line will be denied.
- Modifiers must be billed on the claim in one of the four modifier positions.
- 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, except for the rare exceptions noted in this provider manual section.
- ‹‹Claim submissions must include both an appropriate NCCI-associated modifier and documentation that services were medically necessary and justified.››

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

Modifier 55: Post-Operative Management

CMS mandates that Medically Unlikely Edits (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.

Modifier 59: Distinct Procedural Service

The CMS website contains good information about proper use of modifier 59 (distinct procedural service). This modifier is only to be used if no other descriptive modifier is available.

Modifier XE: Separate Encounter

Modifier XE (separate encounter: a service that is distinct because it occurred during a separate encounter) may be used, for instance, when a surgery is performed in an outpatient facility. The facility submits a claim for room use and some of the supplies. The surgeon submits a claim for the procedure and additional supplies. For correct reimbursement, both providers are required to bill the same procedure code on their claim. However, the claims processing system adjudicates the claims as duplicates and denies or voids one of the claims (Remittance Advice Details [RAD] code 9940, 9941 or void 525). To clarify/facilitate claim payment in this instance, Medi-Cal allows modifier XE to be entered on the claim line after other required modifiers, such as 66 (surgical team) and UA (surgical or non-general anesthesia related supplies and drugs) or UB (surgical or general anesthesia related supplies and drugs).

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.

Pregnancy

For instructions to appropriately bill for the delivery of twins using the mother’s identification number, refer to the billing example.

Claims Processing

In the Medi-Cal processing system, claims will process for NCCI edits before being processed for Medi-Cal edits. NCCI procedure-to-procedure and MUE edits are applied to services performed by the same provider for the same recipient on the same date of service. Procedure-to-procedure 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 procedure-to-procedure and MUE edits are available on the CMS website, *www.cms.gov*. Beginning in 2011 edits related to HCPCS Level II codes are listed in the back of the HCPCS manual.

Claim Denial and Appeal

There is no override for NCCI edits in the Medi-Cal claims processing system. Claims that fail the NCCI 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 1/column 2 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, *www.cms.gov*.

‹‹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.