New Provider Basics - The National Correct Coding Initiative (NCCI)

Are your claims denying for bundling? Bundling continues to be a top claim denial reason for new providers. It may be due to the National Correct Coding Initiative (NCCI). The National Correct Coding Initiative (NCCI) was implemented in 1996. Each Medicare carrier has installed set "edits" in their claims processing system to identify and eliminate the incorrect billing of medical services.

What are Correct Coding Initiative (CCI) edits?
Correct Coding Initiative (CCI) edits are pairs of Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against the CCI tables.

What is the Column 1/Column 2 edit table?
The column 1/column 2 correct coding edit table contains two types of code pair edits. One type contains a column 2 (component) code which is an integral part of the column 1 (comprehensive) code. The other type contains code pairs that should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If two codes of a code pair edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

What is the Mutually Exclusive edit table?
The mutually exclusive edit table contains edits consisting of two codes (procedures) which cannot reasonably be performed together based on the code definitions or anatomic considerations. Each edit consists of a column 1 and column 2 code. If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed (see section entitled "CCI Modifiers").

What modifiers are allowed with the CCI edits?
The following anatomical modifiers are allowed: E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, RC, LT, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9

The following global surgery modifiers are allowed: 25, 58, 78, 79

Other modifiers that are allowed: 59, 91

How should modifier "-25" be reported under the CCI?
Modifier "-25" should be appended to an evaluation and management (E/M) code when reported with another procedure on the same day of service. Appending modifier -25 to the E/M code indicates to the carriers or fiscal intermediaries that as a result of the patient's condition, the physician performed a significant, separately identifiable E/M service above and beyond the other service provided.

How should modifier "59" be reported under the CCI?
Modifier -59 is used to indicate a distinct procedural service. To appropriately report this modifier, append modifier -59 to the column 2 code to indicate that the procedure or service was independent from other services performed on the same day. The addition of this modifier

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indicates to the carriers or fiscal intermediaries that the procedure or service represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different anatomical site or organ system, separate incision/excision, different lesion, or different injury or area of injury (in extensive injuries). When used with a CCI edit, modifier -59 indicates that the procedures are different surgeries when performed at different operative areas or at different patient encounters.

How should Modifier "91" be reported under the CCI?
Modifier -91 should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day. This modifier indicates to the carriers or fiscal intermediaries that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

What is the purpose of the CCI Edits Manual?
The purpose of the National Correct Coding Manual is to promote correct coding nationwide and to assist physicians in coding services correctly for reimbursement. The policies included in the manual are based on coding conventions as defined by the American Medical Association (AMA) CPT manual.

How do I obtain the CCI Edits Manual?
The CMS Website contains a listing of the CCI edits, by specific CPT sections, and is available free for downloading to the public. The CCI Edits manual is also available on the CMS Website. These edits are updated quarterly by AdminaStar Federal. The updates occur in January, April, July, and October. It is important to review these updates to see if the services/procedures you provide are updated. To view and or download this information, visit:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/