National Correct Coding Initiative (NCCI)

Payment Policy ID: RPC.0026.2100

Recent review date: 09/2023

Next review date: 08/2024

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including but not limited to Current Procedural Terminology (CPT®), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on CMS-1500 forms or its electronic equivalent and, when specified, billed on UB-04 forms or its electronic equivalent.

Policy Overview

This policy describes the Medicaid National Correct Coding Initiative (NCCI) program in claims processing by AmeriHealth Caritas Louisiana.

The Centers for Medicare and Medicaid Services (CMS) established the National Correct Coding Initiative program to prevent inappropriate payment for services/supplies furnished by the same provider. Correct coding methodology is based on medical practice standards. Any physician or other qualified health care professional from the same group practice, under the same specialty, and with the same Tax Identification Number (TIN), is considered the same provider.

AmeriHealth Caritas Louisiana follows CMS and state-specific guidelines regarding the Medicaid National Correct Coding Initiative (NCCI) program. Only medically necessary services are reimbursable.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas Louisiana utilizes CMS Medicaid NCCI edits to prevent inappropriate payment for services/supplies. AmeriHealth Caritas Louisiana also applies other rules in processing or reviewing claims in adherence to NCCI and correct coding policy.

There are three (3) provider types that apply to NCCI PTP edits:

- Practitioner (PRA)
- Outpatient Hospital (OPH)
- Durable Medical Equipment (DME)

There are two (2) principal types of Medicaid NCCI edits for services/supplies that impact reimbursement:

- A Medically Unlikely Edit (MUE) is the maximum units of service that are normally allowable for a service/supply represented by a procedure code. For Medicaid NCCI, MUEs are claim line edits. See Reimbursement Policy RPC.0024.2100 regarding reimbursement of services/supplies based on MUEs.

- A Procedure-to-Procedure (PTP) Edit prevents (1) separate payment for services/supplies that are considered inclusive to another service/supply or (2) payment for services/supplies that are considered mutually exclusive.
    - Each PTP edit has (1) a pair of CPT/HCPCS procedure codes and (2) an indicator for modifiers. When procedure codes in an edit pair are received on a claim by the same provider for the same date of service or within the global period of a surgery:
        - The procedure code designated as primary or “Column One” in the edit pair is considered payable. The procedure code designated as non-primary or “Column Two” is considered inclusive or mutually exclusive to the other procedure code.
        - A modifier indicator of “1” indicates that the “Column Two” procedure code is considered payable with an appropriate PTP-associated modifier. A modifier indicator of “0” indicates that the Column Two procedure is not considered payable and will be denied—even with a modifier. See Reimbursement Policies RPC.0010.2100 and RPC.0012.2100 regarding reimbursement for distinct procedural services and the global surgical package, respectively.
            - Any further restrictions that are state-specific imposed on the use of modifiers that are unmet will be denied.

Clean claims must be submitted for accurate reimbursement of services/supplies.

Claims are still subject to review and denial:

- When a modifier is appended but clinical circumstances do not justify its use.
    - For example, a PTP-associated modifier generally should not be used for procedures that were performed during the same patient encounter and in the same or contiguous anatomic sites.
- When multiple procedure codes are billed but a single procedure code comprehensively represents the services that were performed.
    - For example, a unilateral partial mastectomy with axillary lymphadenectomy should not be billed as CPTs 19301 (Mastectomy, partial) and 38745 (Axillary lymphadenectomy; complete), since CPT 19301 (Mastectomy, partial; with axillary lymphadenectomy) comprehensively describes the service.
    - For another example, an open abdominal surgery should not be billed along with CPT 49000 (Exploratory laparotomy) since surgical access is considered integral to the surgical procedure.

Refer to CPT/HCPS manuals for complete descriptions of procedures and their modifiers, NCCI manuals and files for correct coding policies and modifier indicators, and state-specific billing resources for fee schedules and billing guidelines.

Definitions

Medically Unlikely Edit (MUE)
A MUE is the maximum units of service that are normally allowable for the same service or supply, represented as a CPT/HCPCS procedure code, on the same date of service, and by the same provider.

Procedure-to-Procedure Edit (PTP)
A PTP edit prevents payment of services/supplies, represented as CPT/HCPCS procedure codes, that normally should not be reported together for the same date of service or within the global period of a surgery by the same provider.

Edit Sources

I. *Current Procedural* Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM); and associated publications and services.
II. Centers for Medicare and Medicaid Services (CMS) *National Correct Coding Initiative* (NCCI): https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci
III. State fee schedules and other billing resources.

Attachments

N/A

Associated Policies

RPC.0010.2100: Distinct Procedural Service

RPC.0012.2100: Global Surgical Package & Split Surgical Care

RPC.0024.2100: Medically Unlikely Edit

Policy History

09/12/2023	Reimbursement Policy Committee Approval
08/25/2023	Removal of Policy Implemented by AmeriHealth Caritas from Policy History section
01/10/2023	Template Revised Revised preamble Removal of Applicable Claim Types table Coding section renamed to Reimbursement Guidelines Added Associated Policies section