Payment Policy: CMS Correct Coding Initiative - NCCI Edits

Reference Number: FC.PP.020
Product Types: ALL
Last Review Date: 11/1/2022

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview[1]

The health plan administers unbundling edits based on the Centers for Medicare and MedicaidServices (CMS) National Correct Coding Initiative (NCCI). These edits are further defined asprocedure-to-procedure (PTP) code pair edits. The health plan administers these edits for professional and outpatient facility claims.

CMS developed the NCCI edits to promote national correct coding principles and facilitate correct provider reimbursement for medical services performed on patients. The NCCI edit reimbursement methodologies dictate that when two related procedure codes are billed for the same member, by the same provider and on the same date of service, only the most comprehensive of those codes is reimbursable. Therefore, physicians should not report multiple CPT codes when a single, more comprehensive code represents all services performed.

The Health Plan administers automated prepayment claims edits to incorrectly billed code pairs.

CMS organizes the code pairs into column 1/column 2 edits. The column 2 codes represent the code that should not be payable. The column 1 code is the more comprehensive code. This file also contains mutually exclusive code pairs. Mutually exclusive procedures are two procedures that could not have been performed during the same patient encounter because of anatomic, temporal or gender considerations.

The CMS NCCI edit reimbursement methodologies are based on correct coding principlesestablished by the American Medical Association (AMA) CPT manual, national and localpolicies, public-domain specialty society groups, current medical practice etc.

The CMS publishes a reference document, the ***NCCI Policy Manual for Medicare and Medicaid Services*** to offer insight into the reimbursement policies used to develop the edits.

The CMS NCCI edit tables are updated on an annual basis and loaded on the CMS website listedbelow. It's Fidelis Care's policy to apply Medicare NCCI for Medicare product and Medicaid NCCI for Non-Medicare product. The NCCI edits are based on member line of business not provider contracted reimbursement fee schedules.

Medicare NCCI :
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

[1] Please note that the current policy list on the provider portal is not exhaustive. Fidelis Care may from time to time employ a vendor that applies policies to specific services; in such circumstances, the vendor's guidelines may also be used to determine whether a service has been correctly coded. Other policies or contract terms may further determine whether a technology, procedure or treatment is payable by Fidelis Care.

Non-Medicare NCCI **:**
https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

Application

PTP edits apply to both professional and outpatient facility claims on a prepayment basis.

Outpatient Code Editor

PTP edits for outpatient institutional providers subject to the Outpatient Prospective Payment System (OPPS) and hospitals that are non-OPP are housed within the OutpatientCode Editor (OCE).

Policy Description[2]

Modifier Use

Specific modifiers may be used to indicate that a clinical circumstance made reporting of the two codes appropriate. The use of these modifiers is validated by the coding review team on a prepayment basis to ensure coding appropriateness and adherence to correct coding principles. The patient's situation must support use of the modifier. Providers should not use modifiers solely to bypass edits.

Each NCCI PTP edit is assigned a specific modifier indicator. Based on the indicator assigned, 1) the provider may not use a modifier to override the edits, 2) a modifier may be used under appropriate circumstances, or 3) the edit has been deleted and the modifier is no longer appropriate.

Modifier Indicators

CMS NCCI Modifier Indicators	Description
0	Modifiers may not be used to override edits for the particular code pair scenario
1	Modifier may be used (with appropriate clinical documentation) to override the edit
9	Procedure-to-procedure code edit has been deleted and modifier is no longer appropriate for use

Modifiers for use with the NCCI column 1/column 2 edits are listed below.When the modifier(s) is necessary, apply to the column 2 code.

- ***Anatomical Modifiers***
  E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- ***Global Surgery Modifiers***
  -24, -25,-57, -58, -78, -79.
- ***Additional Modifiers***
  -27, -59, -91, -XE, -XS, -XP, -XU

[2] Please note that the corresponding policy is regarding correct coding and not medical necessity.

Reimbursement[3]

The code editing software analyzes professional and outpatient institutional claims for adherence to correct coding principles. The software's logic contains the CMS NCCI column 1/column 2 tables and will reference these tables to determine when multiple procedure codes were billed instead of a single, more comprehensive code. When this occurs, these services will be denied.

The Health Plan will deny all claims billed with an NCCI procedure-to-procedure CPT (PTP) code combination.

Prepayment Clinical Review of Appropriate Use of Modifier

The health plan will conduct prepayment coding validation of all PTP edit combinations billed with a valid NCCI modifier. The health plan's coding review team will conduct claim coding review to determine if the modifier is appropriate for the coding scenario.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registeredtrademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all- inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
NA	NA

[3] Please be advised that authorization does not guarantee reimbursement and to receive reimbursement, providers should submit a claim for services rendered (member eligibility should be re-confirmed at the time the service is rendered).

Modifier	Descriptor
E1	Upper Left, Eyelid
E2	Lower Left, Eyelid
E3	Upper Right, Eyelid
E4	Lower Right, Eyelid
FA	Left Hand, Thumb
F1	Left Hand, Second Digit
F2	Left Hand, Third Digit
F3	Left Hand, Fourth Digit
F4	Left Hand, Fifth Digit
F5	Right Hand, Thumb
F6	Right Hand, 2nd Digit
F7	Right Hand, 3rd Digit
F8	Right Hand, 4th Digit
F9	Right Hand, 5th Digit
TA	Left Foot, Great Toe
T1	Left Foot, 2nd Digit
T2	Left Foot 3rd Digit
T3	Left Foot, 4th Digit
T4	Left Foot, 5th Digit
T5	Right Foot, Great Toe
T6	Right Foot, 2nd Digit
T7	Right Foot, 3rd Digit
T8	Right Foot, 4th Digit
T9	Right Foot, 5th Digit
LT	Left Side
RT	Right Side
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
RC	Right Coronary Artery
LM	Left Main Coronary Artery
RI	Ramus Intermediary Coronary Artery
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a PostoperativePeriod
25	Significant, Separately Identifiable Evaluation and ManagementService by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Service

47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
AA	Anesthesia Services Performed Personally by Anesthesiologist
AD	Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures
AR	Physician Provider Services in a Physician Scarcity Area

AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery
QK	Medical direction of two, Three, or four concurrent anesthesia procedures involving qualified individuals.
QS	Monitored anesthesia care service
QW	CLIA Waived Test
QX	CRNA Service : With Medical Direction by a Physician
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.
QZ	CRNA Service: Without medical direction by a physician
TC	Technical Component
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner

ICD-10 Codes	Descriptor
NA	NA

Definitions

1. ***HealthCare Common Procedure Coding System*** (HCPCS), Level I Modifiers: Alsoknown as CPT modifiers consisting of two numeric digits. These modifiers are in therange of 22-99. The list is updated annually by the AMA.
2. ***HealthCare Common Procedure Coding System*** (HCPCS), Level II Modifiers: Alsoknown as the HCPCS modifiers and consist of two alpha-numeric characters. These modifiers are in the range of AA-VP. The list is updated annually by the CMS.
3. ***Modifier***: Two digit numeric or alpha-numeric descriptor that is used by providers to indicate that a service or procedure has been altered by a specific circumstance, but theprocedure code and definition is unchanged.
4. ***Modifiers Affecting Payment***: Modifiers which impact how a claim or claim line will bereimbursed.
5. ***Patient Encounter****:* An interaction between a health care provider and a patient.
6. ***CMS NCCI:*** Centers for Medicare and Medicaid Services, National Correct CodingInitiative. The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The Centers for Medicare & Medicaid Services (CMS) owns the NCCI program and is responsible for all decisions regarding its contents. The 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 CMS annually updates the National Correct Coding Initiative

Policy Manual for Medicare Services. The NCCI Policy Manual should be used by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits.

Related Documents, Resources or References

1. *Current Procedural Terminology (CPT®)*
2. *Current HCPS Level II*
3. *Current ICD-10-CM Official Code Set*
4. *FC.PP.001 Claim Validation of Modifier 25*
5. *FC.PP.002 Claim Validation of Modifier 59*
6. *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*
7. *https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html*
8. *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric- HCPCS.html*
9. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMSpublications and services.*

Revision History	
11/1/2022	Annual review. References reviewed and updated.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Fidelis Care. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Fidelis Care retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Fidelis Care has no control or right of control. Providers are not agents or employees of Fidelis Care.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.