

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1124	Date: DECEMBER 8, 2006
	Change Request 5422

Subject: Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 13.0, Effective January 1, 2007

I. SUMMARY OF CHANGES: This is the normal update to the CCI procedure to procedure edits.

New/Revised Material

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1124	Date: December 8, 2006	Change Request 5422
-------------	-------------------	------------------------	---------------------

SUBJECT: Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 13.0, Effective January 1, 2007

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

I. GENERAL INFORMATION

The latest package of Correct Coding Initiative (CCI) edits, Version 13.0, effective January 1, 2007, will be available via the CMS Data Center (CDC). A test file will be available on or about November 2, 2006, and the final file will be available on or about November 17, 2006.

Version 13.0 will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables: Column 1/ Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits.

A. Background: The Centers for Medicare and Medicaid Services developed the National Correct Coding Initiative to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

B. Policy: The coding policies developed are 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 practice and review of current coding practice.

II. BUSINESS REQUIREMENTS

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A	D	F	C	D	R	Shared-System Maintainers				OTHER
		/	M	I	A	M	H	F	M	V	C	
		B	E		R	E	H	I	C	S	W	
		M	M		I	C		S	S	S	F	
		A	A		E			S				
		C	C		R							
5422.1	The regional office correct coding initiative (RO CCI) representatives should access the files from the CDC in the same manner they downloaded the previous versions. The filenames for the regions are: Test File: MU00.@BF12372.CCIALl.MEEDIT@S.TEST01.V130 MU00.@BF12372.CCIALl.CMPEDI@TS.TEST01.V130	X			X							RO

									F I S S	M C S	V M S	C W F	
5422.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Val Allen, (410) 786-7443

Post-Implementation Contact(s): Val Allen, (410) 786-7443

VI. FUNDING

A. For TITLE XVIII Contractors, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.