

INTRO.doc  
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INTRODUCTION  
FOR  
NATIONAL CORRECT CODING POLICY MANUAL  
FOR PART B MEDICARE CARRIERS

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## **Introduction**

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted. Section 6102 of P.L. 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, Payment for Physicians' Services. This section of the Act provided for replacing the previous reasonable charge mechanism of actual, customary, and prevailing charges with a resource-based relative value scale (RBRVS) fee schedule that began in 1992.

With the implementation of the Medicare Fee Schedule, it was increasingly important to assure that uniform payment policies and procedures were followed by all carriers so that when the same service is rendered in various carrier jurisdictions, it is paid for in the same way. In addition, accurate coding and reporting of services by physicians was a major concern to guarantee proper payment.

## **Purpose**

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (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.

Although the NCCI was initially developed for use by Medicare Carriers to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries to process Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI.

CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore,

since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" (NEMB) form.

### **Correct Coding**

Procedures should be reported with the HCPCS/CPT codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment.

Correct coding requires reporting a group of procedures with the appropriate comprehensive code. Examples of unbundling are described below:

- Fragmenting one service into component parts and coding each component part as if it were a separate service. For example the correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate.

- Reporting separate codes for related services when one comprehensive code includes all related services. An example of this type is coding a total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries (CPT code 58150) plus salpingectomy (CPT code 58700) plus oophorectomy (CPT code 58940) rather than using the comprehensive CPT code 58150 for all three related services.

- Breaking out bilateral procedures when one code is appropriate. For example, bilateral mammography is coded correctly using CPT code 76091 rather than incorrectly submitting CPT code 76090-RT for right mammography and CPT code 76090-LT for left mammography.

- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate. A laboratory should bill CPT code 80048, (Basic metabolic panel), when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multichannel tests. It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520 in addition to the CPT code 80048 unless one of these laboratory tests was performed at a different time of day to obtain follow-up results, in which case a modifier -91 would be utilized.

- Separating a surgical approach from a major surgical service. For example, a provider should not bill CPT code 49000 for exploratory laparotomy and CPT code 44150 for total abdominal colectomy for the same operation because the exploration of the surgical field is included in the CPT code 44150.

### **Policy Manual Conditions and Format**

The National Correct Coding Policy Manual and edits have been developed for application to services billed by a single provider for a single patient on the same date of service.

It is important to recognize that the National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices than the previous "rebundling" program instituted by CMS, formerly HCFA, in 1992. An understanding of the general policies is necessary to understand the different types of code pair edits that are listed in the Initiative.

The National Correct Coding Policy Manual and Edits were initially based on evaluation of procedures referenced in the 1994 *CPT Manual* and HCPCS Level II codes. An ongoing refinement program has been developed to address annual changes in CPT codes and instructions, either additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes will occur based on changes in technology, in standard medical practice and from continuous input from the AMA and various specialty societies.

The National Correct Coding Policy Manual includes a Table of

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Contents, an Introduction, and 13 narrative chapters. As shown in the Table of Contents, each chapter corresponds to a separate section of the *CPT Manual* except Chapter I which contains general correct coding policies, Chapter XII which addresses HCPCS Level II codes under the Part B Carriers' jurisdiction, and Chapter XIII which summarizes Category III codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

This policy manual in general utilizes paraphrased descriptions of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's *Current Procedural Terminology (CPT) Manual* and CMS's HCPCS Level II code descriptors for complete definitions of the codes.

This policy manual and the edits were developed for the purpose of encouraging consistent and correct coding and of controlling inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

### **Edit Development and Review Process**

The NCCI undergoes constant refinement publishing four versions annually. Medicare Carriers implement the versions effective January 1, April 1, July 1, and October 1. Changes in NCCI come from three sources: (1) additions, deletions or modifications to CPT or HCPCS Level II codes or *CPT Manual* instructions; (2) CMS policy initiatives; and (3) comments from the AMA, national or local medical/surgical societies, Medicare contractor medical directors, providers, billing consultants, etc.

CMS notifies the AMA and national medical/surgical societies of the quarterly changes in NCCI. Additionally, CMS seeks comment from national medical/surgical societies before implementing many types of changes in NCCI. Although national medical/surgical societies generally agree with changes CMS makes to NCCI, CMS carefully considers those adverse comments received. When CMS decides to proceed with changes in NCCI contrary to the comments of national medical/surgical societies, it does so after due consideration of those comments and other information available to CMS.

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## **Sources of Information about NCCI**

The CMS website contains:

- 1) a copy of the National Correct Coding Policy Manual for Medicare Part B Carriers  
(<http://www.cms.hhs.gov/physicians/cciedits/nccmanual.asp>);
- 2) a listing of all NCCI edits  
(<http://www.cms.hhs.gov/physicians/cciedits/default.asp>);  
and
- 3) NCCI Questions and Answers  
(<http://www.cms.hhs.gov/medlearn/ncci.asp>).

## **Correspondence to CMS about NCCI and its Contents**

The NCCI is maintained for CMS by a Program Safeguard Contractor (PSC), Reliance Safeguard Solutions, Inc., and its subcontractor, AdminaStar Federal, Inc. If you have concerns regarding the content of the edits or this manual, please submit your comments in writing to:

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CMS makes all decisions about the contents of NCCI and this manual. Correspondence from AdminaStar Federal reflects CMS's policies on coding and NCCI.