National Correct Coding Initiative (NCCI)

Reimbursement Policy ID: RPC.0026.01CH

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & 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. The health plan 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 Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include 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 health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes the National Correct Coding Initiative (NCCI) program in claims processing by the health plan.

The Centers for Medicare & Medicaid Services (CMS) established the NCCI program to prevent inappropriate payment for services or 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, within the same specialty and the same Tax Identification Number (TIN), is considered the same provider.

The health plan follows CMS and state-specific guidelines with regard to the National Correct Coding Initiative (NCCI) program. Only medically necessary services are reimbursable.

Exceptions

N/A

Reimbursement Guidelines

The health plan uses CMS NCCI edits to prevent inappropriate payment for services/supplies. CHIP also applies other rules in processing or reviewing claims in adherence to NCCI and correct coding policy.

There are two types of NCCI edits for services/supplies that impact reimbursement:

- A Medically Unlikely Edit (MUE) is the maximum number of units of service that are normally allowable for a service/supply represented by a procedure code. For NCCI, MUEs are claim line edits. See Reimbursement Policy RPC.0024.01CH 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.0010.01CH and RPC.0012.01CH regarding reimbursement for distinct procedural services and the global surgical package, respectively.
            - Any further restrictions the Commonwealth of Pennsylvania Children’s Health Insurance Program imposes on the use of a modifier that is 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.
    - Another example, an open abdominal surgery should not be billed along with CPT 49000 (Exploratory laparotomy), because 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)

An MUE is the maximum number of units of service that are allowed 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 surgery by the same provider.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding health plans Clinical Policies.
VII. Applicable health plans provider manual.
VIII. Commonwealth of Pennsylvania Children's Health Insurance Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0010.01CH Distinct Procedural Service
RPC.0012.01CH Global Surgical Package
RPC.0024.01CH Medically Unlikely Edit
RPC.0033.01CH Multiple Procedure Payment Reduction

Policy History

09/2026	• Removed the next review date • Replaced the plan name with "the health plan"
07/2026	Reimbursement Policy Committee Approval
06/2026	Annual Review • No major changes
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval