AmeriHealth Caritas Louisiana

National Correct Coding Initiative (NCCI)

Reimbursement Policy ID: RPC.0026.2100

Recent review date: 10/2026

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 primary purpose of National Correct Coding Initiative (NCCI) edits is to prevent improper payments in claims by identifying and preventing incorrect or inappropriate code combinations. NCCI edits are used to ensure that claims are coded correctly and that services are billed appropriately. They help to identify and reduce errors in coding, which can lead to inaccurate payments and potential penalties.

The health plan follows CMS and state-specific guidelines regarding the Medicaid National Correct Coding Initiative (NCCI) program.

Exceptions

Does not apply to Rural Health Clinics (RHC's), Federally Qualified Health Clinics (FQHC's), or

Reimbursement Guidelines

The health plan uses CMS Medicaid NCCI edits to prevent inappropriate payment for services/supplies. The health plan 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 types of Medicaid 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 specific HCPCS/CPT code on a given date of service for a single beneficiary. For Medicaid NCCI, MUEs are claim line edits. Claims reporting units of services higher than the MUE may be denied by the Plan. See Reimbursement Policy RPC.0024.2100 regarding reimbursement of services/supplies based on MUEs.

- A Procedure-to-Procedure (PTP) edit identifies pairs of HCPCS/CPT codes incorrectly reported together. The edits prevent separate payment for services/supplies that are inclusive to another service/supply.
    - Each PTP edit has a pair of CPT/HCPCS procedure codes and an indicator for modifiers.
        - The procedure code designated as primary or "Column One" in the edit pair is payable. The procedure code designated as non-primary or "Column Two" is inclusive or mutually exclusive to the other procedure code.
        - A modifier indicator of "1" indicates that the "Column Two" procedure code is payable with an appropriate PTP-associated modifier. A modifier indicator of "0" indicates that the Column Two procedure is not payable. Inappropriate application of a modifier to a code to bypass an MUE or PTP code pair edit will be denied. Refer to reimbursement policies RPC.0010.0000 and RPC.0012.0000 regarding reimbursement for distinct procedural services and the global surgical package.
        - State-specific guidelines for use of NCCI edits are also applicable.

Claims are 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 is 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. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th Revision.
IV. Clinical Modification (ICD-10-CM).
V. Medicaid Fee Schedule(s).

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
RPC.0033.2100 Multiple Procedure Payment Reduction

Policy History

10/2026	Reimbursement Policy Committee Approval
09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
06/2026	Annual Review • No major changes
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval

05/2025	Annual review • No major changes
04/2025	Revised preamble
09/2024	Reimbursement Policy Committee Approval
09/2024	Annual review • No major changes
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