



INSTIL<sup>®</sup> HEALTH



# ClaimsXten

## Correct Coding Initiative

**Published by Provider Relations and Education**  
**Your Partners in Outstanding Quality, Satisfaction and Service**

Revised: October 2024

*In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and the health plan, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.*

## Table of Contents

Introduction .....	2
What is ClaimsXten? .....	2
What is NCCI?.....	3
ClaimsXten Rules – Phase I .....	4
ClaimsXten Rules – Phase II .....	8
Claim Adjustment Reason Codes (CARCs) .....	12
Remittance Advice Remark Codes (RARCs) .....	13
Additional Resources .....	14

## Introduction

Accurate coding and reporting of services on medical claims submitted to InStil Health is critical in assuring proper payment to providers.

ClaimsXten allows InStil health to better validate claims-coding accuracy and more closely align claims adjudication with medical policies, benefit plans, and the Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI). The purpose of NCCI is to control improper coding leading to incorrect payment for medical claims.

For providers, implementation of the ClaimsXten software means that correct coding on claims submitted to InStil Health will be more important than ever.

## What is ClaimsXten?

ClaimsXten is robust code-auditing software designed to ensure health insurance claims are coded properly. The software relies on clinically supported rules and logic influenced by national medical societies, current coding practices and the NCCI.

ClaimsXten contains rules, each of which consists of the logic necessary to execute a specific payment policy or guideline. Each rule has an associated set of clinical data that, when applied, results in an edit. The edit is a recommendation to deny, review, modify, or allow a specific claim line.

ClaimsXten simplifies payment rules and analyzes claims in the context of claims history. It offers enhanced analysis of coding for issues such as deleted CPT codes, unbundled services, appropriateness of procedures for age and gender, invalid modifiers, medically unlikely number of units for the same date of service, and investigational procedures.

The first phase of ClaimsXten consists of edits that apply to providers that bill professionally.

Providers will see benefits of the ClaimsXten upgrade that include:

- Improved adjudication accuracy and consistency
- Streamlined claims adjudication
- Fewer manual reviews
- Enhanced payment transparency
- Reduced appeals
- Clinically supported rules and logic

## What is NCCI?

The ClaimsXten auditing logic better aligns InStil Health's claims adjudication with CMS' National Correct Coding Initiative.

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding and incorrect payments for medical services. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

According to the [NCCI Policy Manual](#), NCCI includes three types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code Edits.

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.

Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

## ClaimsXten Rules – Phase I

The rules below include a description and an example of how each rule is applied. Some examples include procedure codes which do not represent all applicable coding. Procedure codes are updated periodically, and the coding referenced is current and valid as of the date of this publication.

Rule	Description	Example
<b>CMS Correct Coding Initiative</b>	Recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in National Correct Coding Initiative (NCCI).	When procedure code 0213T (injection with ultrasound guidance) (column two code) is submitted with 19304 (mastectomy) (column one code), procedure code 0213T is recommended for denial.
<b>Unbundling</b>	Recommends the denial of claim lines where a procedure is submitted with another procedure that is one of the following: a more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service.	Procedure code 49000 (exploratory laparotomy) is recommended for denial when submitted with procedure code 44010 (duodenotomy, exploration biopsy).
<b>Allowed Once Per Date of Service</b>	Recommends the denial of claim lines containing procedure codes that should only be performed once per date of service.	Bilateral tenotomy procedure 27392 is recommended for denial if submitted more than once on the same date of service.
<b>Medicare Medically Unlikely Edit (MUE) DME</b>	This rule checks for the line quantity billed on a claim line and recommends denial if the line quantity exceeds the MUE for the HCPCS/CPT code with MAI of 1, 2 or 3 reported by the same provider or across providers (depending on the provider setting configuration), for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not.	A claim is submitted for A4235 (replacement battery, for use with home blood glucose monitor) with seven units, across three days. The line quantity is spread across the three days to determine the quantity per day: $7 \text{ units} / 3 \text{ days} = 2.33$ per day. The total is rounded to the nearest whole number, 2. The MUE for A4235 is 2 and the MAI is 1. Only this line is considered and the daily value is equal to the MUE allotted, therefore, the line will be allowed.
<b>Allowed Multiple Times Per Date of Service</b>	Recommends the denial of claim lines when the quantity billed for the procedure code exceeds the maximum allowed per date of service.	Procedure 29125 (for short arm splint application), has a maximum allowance of twice per date of service. If the submission of the procedure is three times, the third occurrence is recommended for denial.

Rule	Description	Example
<b>CMS Always Bundled Procedures</b>	Recommends the denial of claim containing lines with procedure codes indicated by CMS as always bundled when billed with any other procedure not indicated as always bundled for the same member, the same provider and for the same date of service.	Procedure code 36416 (collection of blood specimen) is identified by CMS as a bundled service. When this procedure is submitted with another procedure that is not considered a bundled service (for example, 33510, coronary artery bypass), 36416 is recommended for denial.
<b>Base Code Quantity</b>	Recommends the denial of claim lines containing base codes billed with a quantity greater than one per date of service.	When procedure code 63102 (vertebral body resection) is submitted more than once for the same date of service, and no other line on same claim or in history, the line is recommended for denial and replaces procedure code 63102 with a quantity of 1.
<b>New Patient Code for Established Patient</b>	Recommends the denial of claim lines containing a new patient evaluation and management (E&M) code for established patients.	New patient code 99204 is recommended for denial when submitted within three years (by the same provider or provider group/specialty) of another E&M code. It is replaced with the appropriate established patient code as indicated in the new patient crosswalk.
<b>Same Day Visit</b>	Recommends the denial of claim lines with E&M codes billed on the same date of service as a procedure code within a global period.	E&M procedure code 99213 is recommended for denial when submitted on the same date of service as procedure code 49000.
<b>Bilateral</b>	Identifies the same code billed twice for the same date of service where the first code has the bilateral -50 modifier appended. The rule recommends the denial of the second submission regardless if submitted with or without a bilateral modifier.	When myringotomy procedure code 69420 is submitted twice and at least one of the lines has modifier -50, the line without the modifier -50 (or the second line with modifier -50) is recommended for denial.
<b>Post-Operative Visit</b>	Recommends the denial of claim lines containing E&M codes billed within the post-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the 90-day post-op period of procedure code 49000.
<b>Co-Surgeon</b>	Identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have not met the criteria for submitting a procedure for co-surgery payment according to CMS.	Procedure A4890-62 is recommended for denial as this procedure does not warrant co-surgeons according to CMS.

Rule	Description	Example
<b>Pre-Operative Visit</b>	Recommends the denial of claim lines containing E&M codes billed within the pre-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the one-day pre-op period of procedure code 49000. The diagnosis code is the same on the claim line for both procedures.
<b>Medicare Medically Unlikely Edit (MUE) – Practitioner</b>	Recommends the denial of claim lines where the MUE for a CPT/HCPCS code is exceeded by the same provider, for the same member, on the same date of service. Procedure codes with an MUE adjudication indicator (MAI) of 1 will edit as a single line edit. Procedure codes with an MAI of 2 or 3 will consider frequency from other claim lines to determine if the MUE is met or exceeded. This rule will evaluate date ranges to determine if the MUE has been met or not.	A provider submits a claim with procedure code 11771 (excision of pilonidal cyst or sinus; extensive), line quantity =2 and 2-days' time interval. This procedure code daily MUE allowed value is 1 and the MAI =2. The calculated individual line quantity is 1 so the current claim line will exit the rule.
<b>Add On Without Base Code</b>	<p>There are CPT and HCPCS defined add-on codes for which the AMA has assigned specific base code(s). This rule audits those codes, and recommends the denial of claim lines containing the add-on codes when the defined base code cannot be found by the same member for the same date of service.</p> <p>In addition to the add-on code content in this rule, this rule also audits that vaccine supply and immune globulin supply codes are submitted with their associated administration procedure code as is required according to CPT Guidelines.</p>	CPT add-on procedure code 15787 (abrasion; each additional 4 lesions or less) is submitted without the base procedure code 15786 (abrasion; single lesion) present on the claim or in any history lines. Procedure code 15787 is recommended for denial.
<b>Assistant Surgeon</b>	Recommends the denial of claim lines containing procedure codes inappropriately submitted with an assistant surgeon modifier 80, 81, 82, or AS in any of the four modifier positions.	When procedure code 10021 (fine needle aspiration) is submitted with modifier -80, the line is recommended for denial.
<b>Modifier To Procedure Validation – Payment Modifiers</b>	Recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Anesthesia procedure 00560 is recommended for denial when submitted with modifier -50.

Rule	Description	Example
<b>Multiple Code Rebundling</b>	Recommends the denial of claim lines when another more comprehensive procedure exists. If the more comprehensive code is also submitted for this member by the same provider, for the same date of service, the component codes will be denied and the comprehensive code will be recommended for reimbursement. If the more comprehensive code is not submitted for this member by the same provider for the same date of service, it will be added to the claim.	When laboratory procedures 82465 (cholesterol), 83718 (HDL cholesterol), and 84478 (triglycerides) are submitted together for the same date of service, all are recommended for denial and replaced with the panel code 80061 (lipid panel).
<b>Global Component</b>	Identifies instances where the sum of all payments (total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure. This rule audits for the same member ID, the same date of service, across providers.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by a different provider on the same date of service, 51725-26 is recommended for denial.
<b>CMS Modifier to Procedure Validation</b>	Recommends the denial of claim lines containing invalid procedure code and modifier combinations based on the CMS Physician Fee Schedule (and select DME modifiers) and the date of service.	Procedure code 51784-50 (electromyography studies of anal or urethral sphincter, other than needle) is recommended for denial, as this procedure is not valid with modifier -50.
<b>Modifier To Procedure Validation – Non-Payment Modifiers</b>	Recommends the denial of procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Hysterectomy procedure 58150 is recommended for denial when submitted with modifier –LT.
<b>Duplicate Component Billing</b>	Recommends the denial of claim lines containing procedure codes billed with a professional or technical modifier when the procedure code was previously submitted as a global procedure for the same provider ID for the same member for the same date of service.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by the same provider on the same date of service, 51725-26 is recommended for denial.
<b>Age Code Replacement</b>	Recommends the denial of claim lines containing procedure codes and preventive Evaluation and Management (E&M) codes that are inconsistent with the patient’s age, and replaces the line with the age-appropriate code.	Procedure code 42825 (tonsillectomy, younger than age 12) is replaced with procedure code 42826 (tonsillectomy, age 12 or over) when submitted for a 20-year-old patient.
<b>Age</b>	Recommends the denial of claim lines containing procedure codes inconsistent with the patient’s age.	Maternity procedure code 59400 is recommended for denial when submitted for a 9-year-old patient.

## ClaimsXten Rules – Phase II

The rules below include a description and an example of how each rule is applied. Like the first phase, some examples include procedure codes which do not represent all applicable coding. Procedure codes are updated periodically, and the coding referenced is current and valid as of the date of this publication.

Rule	Description	Example
<b>Duplicate Line Items</b>	<p>Recommends the denial of a claim line that matches a previously submitted claim line on a different claim or the current claim. Fields that must match are the member, provider, procedure code, modifier, date of service, quantity, and billed amount.</p>	<p>Two claims are on file for a member with the same provider, procedure code, and modifier, for the same date and billed amount.</p> <p><b>OR</b></p> <p>A claim is submitted with three lines, but two of the lines have the same procedure code, modifier, quantity, date of service, and billed amount.</p>
<b>Missing Professional Component Modifier</b>	<p>Recommends the denial of a claims lines containing a procedure code submitted without a professional component modifier -26 in a facility setting (POS 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56 or 61).</p> <p>The rule will replace the line with a new line with the same procedure code and the professional component modifier -26.</p>	<p>Laboratory procedure 88106 is submitted without modifier -26 with a POS of 21, 22 or 24 and this claim line is denied.</p> <p>The same procedure (88106) is then added to the claim with the modifier -26 appended for payment.</p>
<b>Obstetrics Package Rule</b>	<p>Audits potential overpayments for obstetric care. It evaluates claim lines to determine if any global obstetric (OB) care codes (defined as containing antepartum, delivery and postpartum services, i.e., 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.</p>	<p>A claim line is submitted with global obstetrical procedure code 59400 (routine obstetric care including antepartum care, vaginal delivery, and postpartum care) on 03/01/2018. In history, global obstetrical procedure code 59400 was previously submitted on 2/1/2018 for the same member and was paid. The claim line would be denied with a Certainty of Apply. Global obstetrical code 59400 was submitted within 322 days of this current submission of global code 59400.</p>

Rule	Description	Example
<b>Inpatient Consultations</b>	Recommends the denial of claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a specified interval of time.	Inpatient consultation code 99252 was previously submitted on another claim for the same member and provider, with a claim line date of service within five days of the date for the current claim line submitted with inpatient consultation code 99253. Both claims have 250.82 as the diagnosis reported. Inpatient consultation code 99253 is denied and replaced with Evaluation and Management services code 99499 (or by the crosswalk value designated in the Consultation Recoding Guide).
<b>Ambulance Bundled Services</b>	Recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.	A claim has a HCPCS code for ground transport (A0428) and a non-ambulance CPT code (A4931) for the same member, same date of service, and by the same provider.  Line 2 (A4931) will deny using Line 1 (A0428) as support.
<b>Ambulance Modifier Procedure Validation</b>	Recommends the denial of ambulance services for the following reasons: <ul style="list-style-type: none"> <li>• Claim lacks an appropriate origin-destination modifier or modifier QL.</li> <li>• Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN).</li> <li>• Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers.</li> </ul>	There are two lines of coding (A0430 and A0435, both with modifier DG) for a supplier (professional) claim.  Both lines will deny, as the modifier is not appropriate for the air ambulance codes submitted.
<b>Valid Ambulance Services</b>	Recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e., mileage code and transport/service code) are required in most ambulance billing scenarios. This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin-destination modifier and institutional claim lines which lack appropriate arrangement modifiers as required.	There are two lines of coding; a mileage code (A0425) and revenue code 540, and a transport/service code (A0428) and revenue code 000 on the same claim ID.  Both lines will deny, as Line 1 (A0425) has a valid mileage code, but an unsupported transport/service code and Line 2 (A0428) has an invalid transport/service code due to the revenue code.

Rule	Description	Example
<b>Ambulance Frequency</b>	Recommends the denial of an ambulance claim line when the frequency exceeds than allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service from.	<p>There is a single line of coding (A0428) reported for the supplier (professional) claim with the quantity of 2 units.</p> <p>The claim will deny, as the frequency (quantity) is exceeded for the A0428.</p>
<b>Local Coverage Determination Procedure to Diagnosis Coverage</b>  <i>Note: Only applies to Medicare Advantage claims.</i>	Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs).	<p><i>Place of Service (POS) Check</i></p> <p>A Medicare Part B claim (POS 22) is submitted for procedure code 11055.</p> <p>The claim line will exit the rule since POS 22 with procedure code 11055 does not qualify for the LCD policy.</p>
<b>National Coverage Determination Procedure to Diagnosis Coverage</b>  <i>Note: Only applies to Medicare Advantage claims.</i>	Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs).	<p><i>Multiple Explicit Diagnoses Covered and Non-covered</i></p> <p>An inpatient facility claim (Bill Type 111) is submitted with procedure code 43645 and several claim diagnoses codes. Per NCD policy, diagnosis code G83.9 is covered, Z00.00 requires additional review and F01.50 is not covered with procedure code 43645.</p> <p>The default rule will evaluate claim level diagnosis fields only for facility claims. The claim line will exit the rule since the diagnosis code G83.9 is identified as covered when submitted with procedure code 43645 according to the applicable NCD policy.</p> <p>This example illustrates how a single covered diagnosis code will satisfy the coverage criteria and outweigh the documentation review and non-covered recommendations.</p>

Rule	Description	Example
<p><b>National Coverage Determination Procedure to Diagnosis Coverage: Exclusionary Lab Policy</b></p> <p><i>Note: Only applies to Medicare Advantage claims.</i></p>	<p>Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions:</p> <p>According to this Exclusionary policy, CMS has a defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list.</p> <p><b>OR</b></p> <p>Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.</p>	<p>An outpatient facility claim (Bill Type 131) is submitted with a procedure code 85049 and claim diagnosis code of D23.9:</p> <p>The default rule will evaluate claim level diagnosis fields only for facility claims. 85049 is denied (with Certainty of APPLY) because diagnosis code D23.9 is in the CMS defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list.</p>
<p><b>National Coverage Determination Procedure to Diagnosis Coverage: Inclusionary Lab Policy</b></p> <p><i>Note: Only applies to Medicare Advantage claims.</i></p>	<p>Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions:</p> <p>According to this Inclusionary policy, CMS has a defined list of "ICD-10-CM Codes Covered by Medicare Program." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list.</p> <p><b>OR</b></p> <p>Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.</p>	<p>An outpatient facility claim (Bill Type 131) is submitted a procedure code 80074 and claim diagnosis code of K76.1:</p> <p>The default rule will evaluate claim level diagnosis fields only for facility claims. 80074 is denied (with Certainty of APPLY) because diagnosis code K76.1 is not in the CMS defined list of "ICD-10-CM Codes Covered by Medicare Program" or in the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list.</p>

## Claim Adjustment Reason Codes (CARCs)

CARCs explain how a claim or service line was processed.

*Note: Phase II may have additional CARCs that apply.*

Code	Description
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
94	Processed in Excess of charges.
95	Plan procedures not followed.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
119	Benefit maximum for this time period or occurrence has been reached.
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

## Remittance Advice Remark Codes (RARCs)

RARCs provide information to explain an adjustment.

*Note: Phase II may have additional RARCs that apply.*

Code	Description
<b>M15</b>	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
<b>M144</b>	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
<b>N19</b>	Procedure code incidental to primary procedure.
<b>N22</b>	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
<b>N129</b>	Not eligible due to the patient's age.
<b>N182</b>	This claim/service must be billed according to the schedule for this plan.
<b>N362</b>	The number of Days or Units of Service exceeds our acceptable maximum.
<b>N390</b>	This service/report cannot be billed separately.
<b>N430</b>	Procedure code is inconsistent with the units billed.
<b>N657</b>	This should be billed with the appropriate code for these services.

## Additional Resources

These links lead to a third-party website. The owner of the site is solely responsible for the contents and privacy policies on their site.

- **CMS:** [www.cms.gov](http://www.cms.gov)
- **National Correct Coding Initiative Edits:**  
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>
- **NCCI Policy Manual Archive (downloads):**  
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html>
- **Medically Unlikely Edits:** <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>