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NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

The National Correct Coding Initiative and Medically Unlikely Edits for Part B Providers

1/22/2025

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Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenters

- Provider Outreach and Education Consultants
  - Arlene Dunphy, CPC
  - Michelle Coleman, CPC

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Objective

To gain an understanding of NCCI edits and proper modifier use.

Understand the MUE adjudication indicators and how the claims are processed.

Understand the different levels of appeals for NCCI and MUE denials.

Agenda

- National Correct Coding Initiative
- Modifiers
- Medically Unlikely Edits
- Redeterminations/Reopenings
- Resources

National Correct Coding Initiative

What Is the NCCI?

- PTP code pair edits
- Developed to promote national correct coding methods
- To control improper coding leading to inappropriate payment for Medicare Part B claims
- Edits to prevent unbundling of services
- Edits are updated quarterly

Coding Conventions Defined

- Coding policies are based on the
  - AMA CPT manual
  - HCPCS manual
  - National and local Medicare policies
  - Coding guidelines developed by national societies

NCCI Edits

- Two types
  - PTP coding edits
    - PTP Edits – physicians
    - PTP Edits – hospitals

NCCI for Medicare

Medicare › Coding & billing › National Correct Coding Initiative (NCCI) edits

National Correct Coding Initiative (NCCI) edits

- Medicare NCCI Policy Manual
- Medicare Correspondence Language Manual
- Medicare NCCI Add-on Code Edits
- Medicare NCCI FAQ Library
- Medicare NCCI Medically Unlikely Edit (MUE) Archive
- Medicare NCCI Medically Unlikely Edits (MUEs)
- Medicare NCCI Procedure to Procedure (PTP) Edits

Medicare National Correct Coding Initiative (NCCI) Edits

NCCI Implementation | **Replacement Files** | **Contact Information** | **Submitting an Appeal**

CMS developed the NCCI program to promote national correct coding of Medicare Part B claims. CMS owns the NCCI program and is responsible for all decisions regarding its contents.

CMS develops its coding policies 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 practices, and a review of current coding practices.

NCCI Implementation

The purpose of the NCCI Procedure to Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians or

NCCI Medicare Manual

Manual by Chapter	Chapter
List of Acronyms (PDF)	N/A
Complete Table of Contents (PDF)	N/A
Introduction to National Correct Coding Initiative Policy Manual for Medicare Services	N/A
General Correct Coding Policies	Chapter 1
Anesthesia Services Current Procedural Terminology CPT codes 00000-01999	Chapter 2
Surgery: Integumentary Systems CPT codes 10000-19999	Chapter 3
Surgery: Musculoskeletal System CPT codes 20000-29999	Chapter 4
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems CPT Codes 30000-39999	Chapter 5
Surgery: Digestive System CPT codes 40000-49999	Chapter 6
Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems CPT Codes 50000-599999	Chapter 7
Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000-69999	Chapter 8
Radiology Services CPT Codes 70000-79999	Chapter 9
Pathology/Laboratory Services CPT Codes 80000-89999	Chapter 10
Medicine, Evaluation and Management Services CPT Codes 90000-99999	Chapter 11
Supplemental Services HCPCS Level II Codes A0000-V9999	Chapter 12
Category III Codes CPT Codes 0001T-0999T	Chapter 13

Where to Find NCCI Edits

- Practitioner PTP Edits

2025 Quarter 1 Edit Files	Date
Practitioner PTP Edits v310r0 (645,134 Records) 0001A/0591T - 25355/G0471	1/1/2025
Practitioner PTP Edits v310r0 (644, 862 Records) 25360/01810 - 36909/J2001	1/1/2025
Practitioner PTP Edits v310r0 (645,279 Records) 37140/013T- 61735/G0471	1/1/2025
Practitioner PTP Edits v310r0 (622,475 Records) 61736/0213T - U0003/U0004	1/1/2025

NCCI Coding

- Column one code is eligible for payment
- Column two code will be denied unless both codes are clinically appropriate
- Indicate the supporting documentation in the medical record

NCCI

- Does not include all possible combinations
  - Providers are obligated to code correctly
- Services that are denied based on PTP code pair edits
  - May not be billed to Medicare beneficiaries
  - Cannot utilize an ABN to seek payment

NCCI Indicators

Modifier Indicator	Descriptor
Indicator 0	Codes should never be reported together by the same provider/same beneficiary/same DOS
Indicator 1	Codes may be reported together only in defined circumstances (identified on claims by specific NCCI-associated modifier)
Indicator 9	Not relevant (edit was deleted)

NCCI Example One

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *- no date	Modifier 0= not allowed 1- allowed 9= not applicable	PTP Edit Rationale
26010	99214	Data	20130701	*	1	CPT Manual or CMS Manual Coding Instructions

NCCI Example Two

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *- no date	Modifier 0= not allowed 1- allowed 9= not applicable	PTP Edit Rationale
93015	93000		19960101	*	1	Standards of medical/surgical practice

Remittance Example and References

Code	Description
CO-16	Claim/service lacks information or has submission/billing errors which is needed for adjudication. Additional information is supplied using remittance advice remarks codes.
Reason Code 236	The procedure or procedure/modifier combination is not compatible with another procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or worker's compensation state regulations/ fee schedule requirements.

- WPC references
- X12 External Code Lists
  - Remittance Advice Remarks Code reference
  - Claim Adjustment Reason Code reference

Modifiers

Appropriate Modifiers

- Modifiers that may be used under appropriate clinical circumstances
  - Anatomic modifiers: E1–E4, FA, F1–F9, TA, T1–T9, LT, RT, LC, LD, RC, LM, RI
  - E/M modifiers: 24, 25, 57
  - Global surgery modifiers: 58, 78, 79
  - Other modifiers: 59, XE, XS, XP, XU, 76, 77, 91, KX
- Documentation must satisfy the criteria required

Repeat Service Modifiers

- Modifier 76 – Repeat procedure by the same physician
- Modifier 77 – Repeat procedure by a different physician
- Modifier 91 – Repeat clinical diagnostic laboratory test to obtain multiple results
- Repeat Procedures – Modifiers 76 and 77
- Proper Use of Modifiers 59 and 91
- MLN® Fact Sheet: *Proper Use of Modifiers 59, XE, XP, XS, and XU*

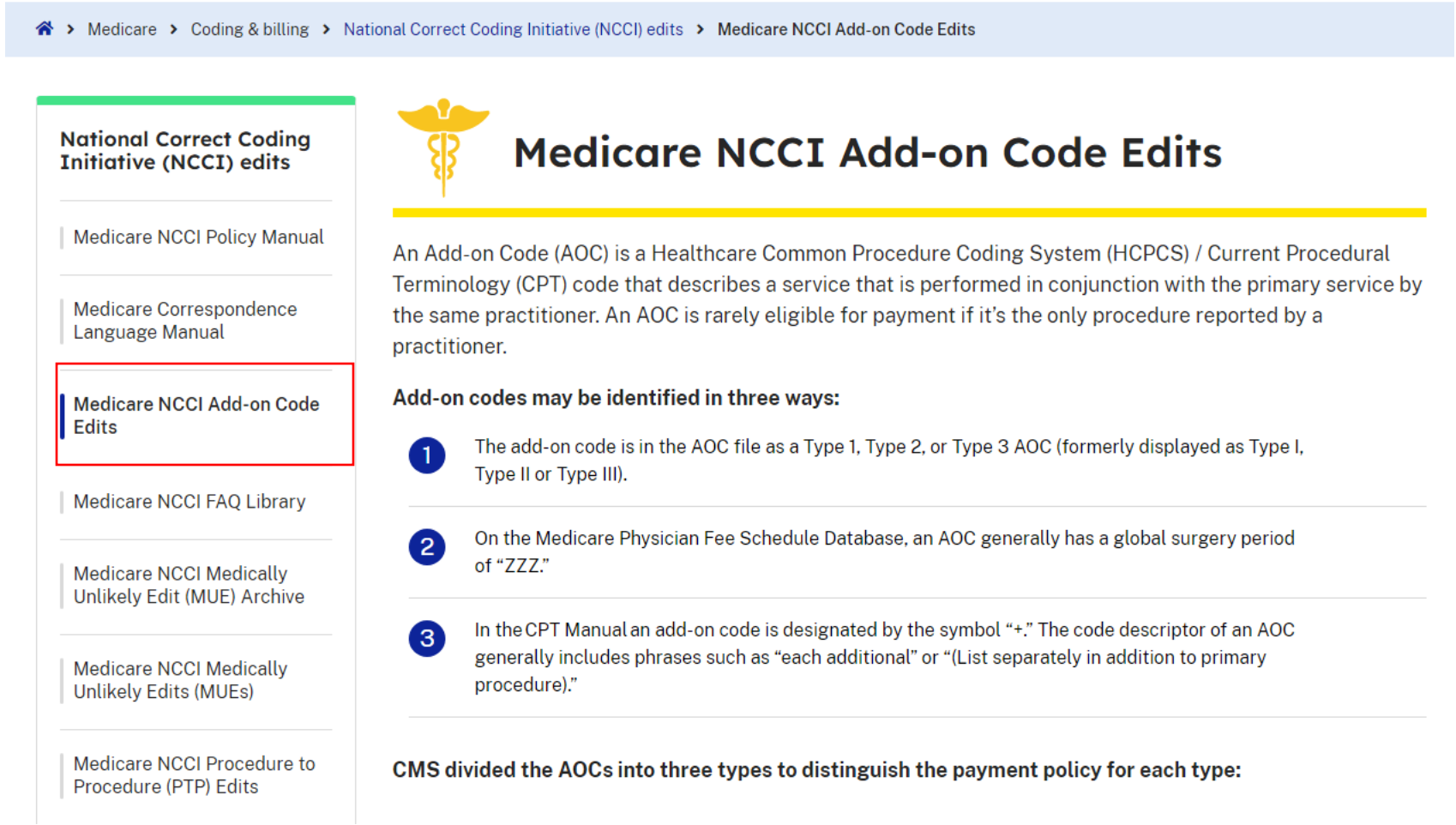
Modifier 59/XE/XS/XP/XU
Distinct Procedural Service

- Used when performed procedure or service distinct or separate from other services performed on same day, such as
  - Different session or patient encounter
  - Different procedure or surgery
  - Different anatomic site
  - Separate lesion
  - Separate injury

Modifiers 59/XE/XS/XP/XU

- Appropriate usage
  - Different session or patient encounter, different procedure or surgery, different anatomical site, or separate injury or area of injury
  - Medical record documentation indicates two separate distinct procedures performed on the same day by the same physician
  - Listed on the column one or column two code (MM11168)
  - Only when there is no other appropriate modifier to use
- Inappropriate usage
  - Code combination does not appear in the NCCI edits
  - Not be appended to an E/M service performed on the same date, see modifier 25
  - NCCI modifier table with a modifier indicator of “0”
  - Medical record documentation does not support the separate and distinct status
  - Exact same procedure code was performed twice on the same day, see modifier 76 or 77
  - A more appropriate modifier exists to identify the services

Add-on Codes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Medicare NCCI Add-on Code Edits
An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Add-on codes may be identified in three ways:
1 The add-on code is in the AOC file as a Type 1, Type 2, or Type 3 AOC (formerly displayed as Type I, Type II or Type III).
2 On the Medicare Physician Fee Schedule Database, an AOC generally has a global surgery period of "ZZZ."
3 In the CPT Manual an add-on code is designated by the symbol "+." The code descriptor of an AOC generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."
CMS divided the AOCs into three types to distinguish the payment policy for each type:

Add-on Codes

- Describes a service always performed in conjunction with another primary service
- Add-on codes identified as a
  - Type I, II or III code
  - Global surgery period of “ZZZ”
  - Designated by the symbol “+”, phrases of “each additional”, “list separately in addition to primary code”
- Rarely ever eligible for payment if it’s the only procedure reported by a practitioner
  - Exception
  - Critical care codes
    - CPT code 99292 may be paid to a physician or other qualified healthcare professional (QHP) who does not bill CPT code 99291 (CPT 99291 is billed by another physician or QHP of the same specialty in the same group on the same day)

Medically Unlikely Edits

Medically Unlikely Edits

- Developed to reduce the paid claims error rate
- Automated prepayment edits
- Do not exist for all HCPCS/CPT codes
- Majority of the edits are publicly available
- Edits are updated quarterly

MUE Types

- Three provider-type choices
  - MUEs
    - Practitioner MUEs
    - DME supplier MUEs
    - Facility outpatient MUEs

MUEs

- MACs may have a unit of service edit that could be more restrictive
  - If so, that edit would be applied to the claim
- If a MUE is more restrictive than a MACs, the more restrictive edit would apply
- MUE values are not utilization guidelines
- MUEs reported less than or equal to a value for a code may still be subjected to medical review

Remittance Example and References

Code	Description
Reason Code 151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
Remark Code N362	Number of days/units exceed maximum.

MUE Downloads

National Correct Coding Initiative (NCCI) edits

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Medically Unlikely Edits Related Downloads

Related Downloads

- DME Supplier Services MUE Table (ZIP) - Effective January 1, 2025; Posted December 2, 2024
- Facility Outpatient Hospital Services MUE Table (ZIP) - Effective January 1, 2025; Posted December 2, 2024
- Practitioner Services MUE Table (ZIP) - Effective January 1, 2025; Posted December 2, 2024
- Earlier MUE tables are available in the Medicare MUE Archive.

MUE Table

CPT/HCPCS Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
92920	3	3 Date of Service Edit: Clinical	Code Descriptor/CPT Instruction

MUE Adjudication Indicator “1”

- This is a **claim line** edit which will deny when units of service are in excess of the MUE, although this may be impacted by the presence of a modifier on the claim line

CPT/HCPCS Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
J7193	4000	1 Line Edit	Clinical: Data

MUE Adjudication Indicator “1” Example

- J7193 Example Total of 4100 units
  - Line 1 = J7193 (MAI 1) – 4000 (MUE is 4000)
  - Line 2 = J7193 76 modifier (MAI 1) – 100 units

CPT/HCPCS Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
J7193	4000	1 Line Edit	Clinical: Data

MUE Adjudication Indicator “2”

- This is an absolute date of service edit. UOS in excess of the MUE value would be considered impossible because of a statute, regulation or sub regulatory guidance. This includes correct coding policy that is binding for both providers and MACs
  - **Note:** When billing for bilateral services and the MAI value is 2, you must bill as a single line item with the 50 modifier

MUE Adjudication Indicator “2” Example

HCPCS/CPT Code	Practitioner Services MUE Value	MUE Adjudication Indicator	MUE Rationale
G0444	1	2 Date of Service Edit: Policy	CMS Policy

MUE Adjudication Indicator “3”

- This is a date of service edit based on clinical benchmarks. If medical necessity for the excess UOS is established through prepayment review of the claim, reopening or redetermination process or through instructions from a higher level of appeal, MACs may bypass these edits and allow the excess UOS
  - **Note:** UOS are counted for all lines of service on the current claim and any prior finalized claim for the same DOS. When that count exceeds the MUE UOS, all claim lines for the code on the current claim are denied, although prior paid and finalized claims are not adjusted. The claim will have to be submitted through a redetermination with medical documentation to support the units of service

MUE Adjudication Indicator “3” Example

CPT/HCPCS Code	Practitioner Services MUE Value	MUE Adjudication Indicator	MUE Rational
82947	5	3 Date of Service Edit: Clinical	Clinical: Data

MUE Adjudication Indicator “3” Example

- 82947 example of seven units (MUE 5)
- Line one – 82947 seven units (Must appeal all units)
- Claim must be appealed with documentation to support additional units in excess of five because it is a DOS edit, which means the system will add up all units for that date regardless of how many claims were submitted

MUE Notes

- MUE denials may be appealed
  - Denials based on coding/billing errors can be addressed via the redetermination process
- MUEs are applicable to the time period in table
- Liability cannot be shifted to the beneficiary
  - ABN issuance in anticipation of a MUE denial is not appropriate

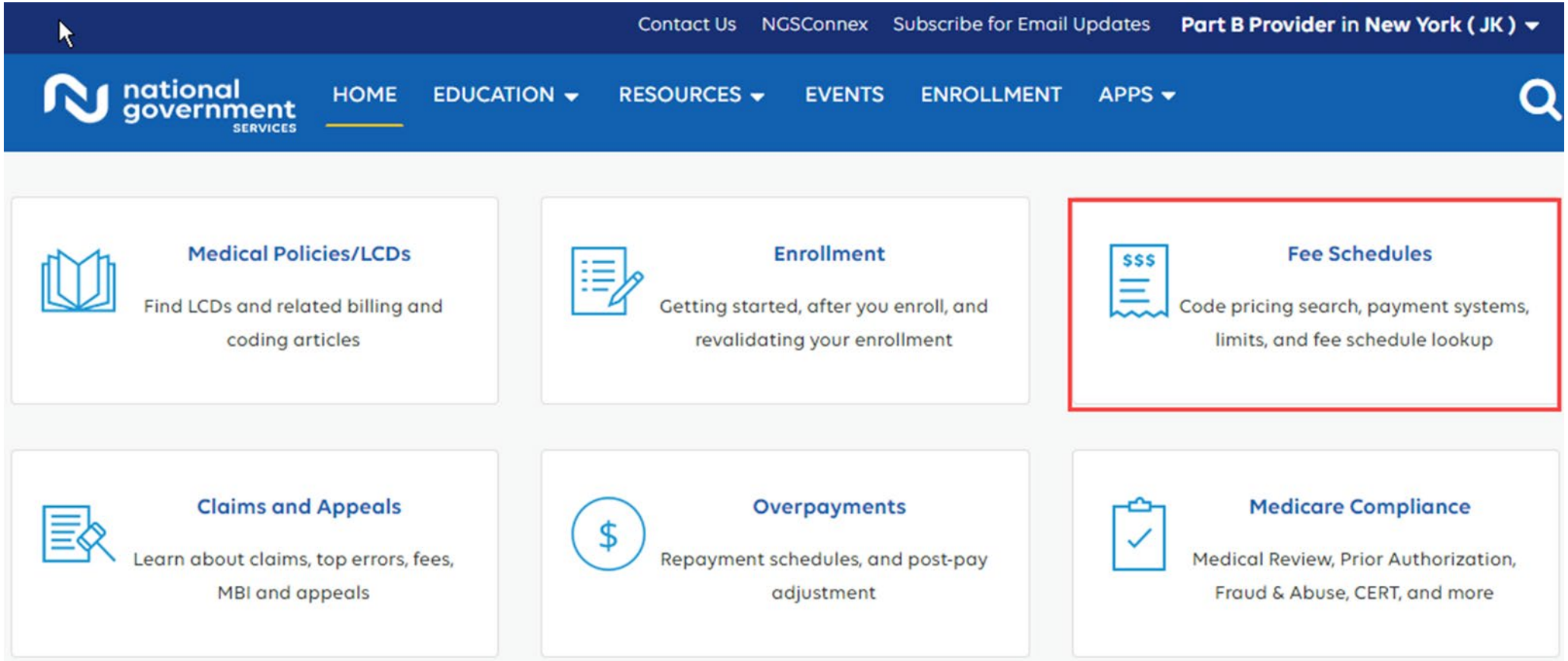
MUE Notes

- ASCs
  - Cannot use modifier 50
    - Bill two UOS on one detail line or
    - Bill separate details using RT/LT modifiers
  - Report procedures with differing modifiers on individual claim lines when appropriate
  - Many MUEs are based on the assumption that correct modifiers are used

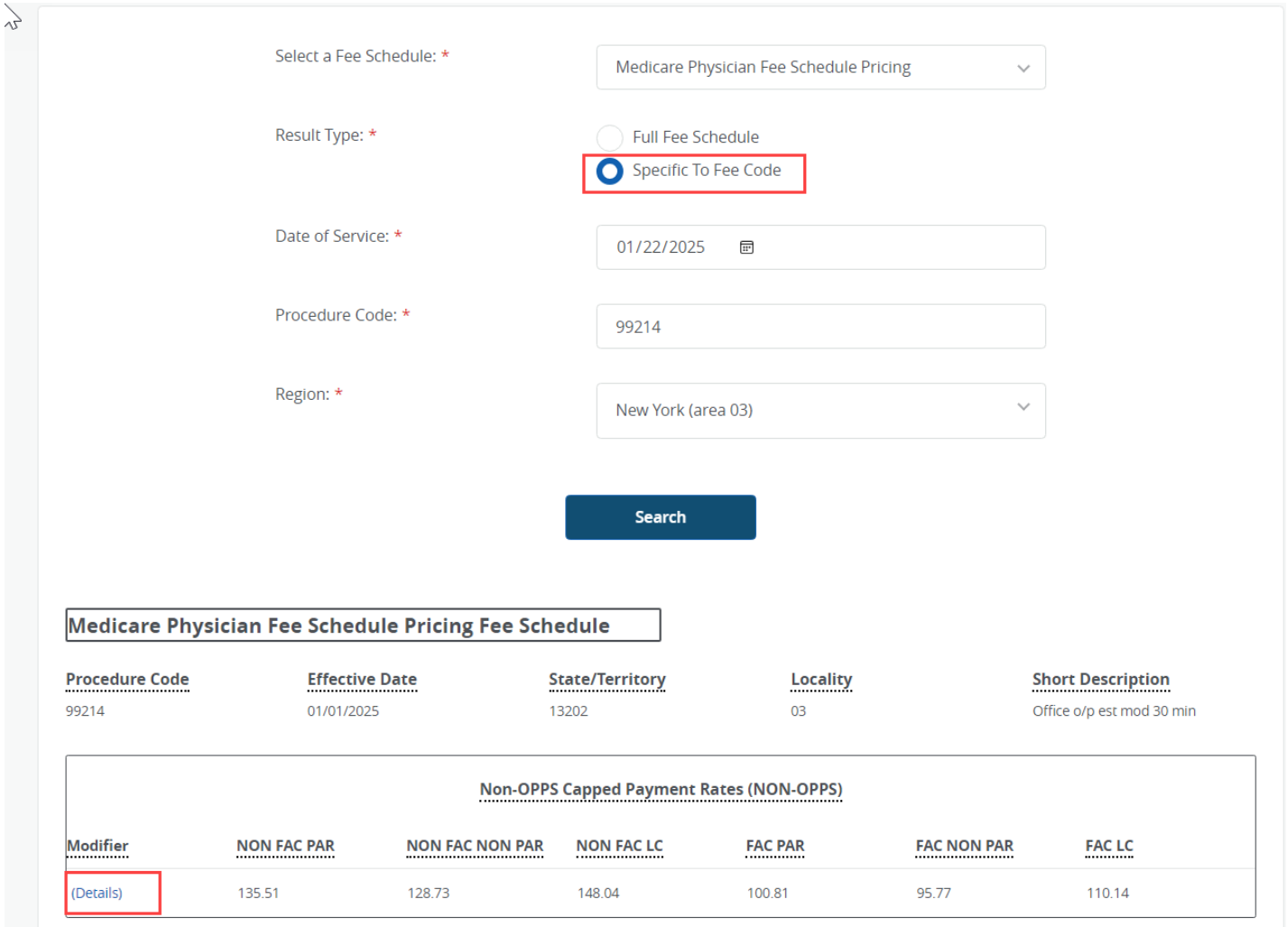
Modifier 50

- Used to report bilateral procedures performed at the same operative sessions as a single line item
  - Do not use modifiers RT/LT when modifier 50 is used
- Applies to any bilateral procedures performed on both sides at the same operative session
- Do not use to report on surgical procedures identified by their terminology as “unilateral or bilateral”
- Report one unit when modifier 50 is reported
- Report anatomic modifiers on individual claim lines

Accessing the Fee Schedule



Fee Schedule Lookup



Medicare Physician Fee Schedule Details

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	135.51	128.73	148.04	100.81	95.77	110.14

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	32.3465	1.0000	1.92	0.83	1.80
Malpractice RVU	**Work GPCI**	**Practice GPCI**	**Malpractice GPCI**	**Reduced Therapy Amt**	**Endoscopic Base**
0.15	1.046	1.106	1.269	44.17	
Global Surgery	**Facility Pricing**	**PC/TC**	**Preoperative Percentage**	**Interoperative Percentage**	**Postoperative Percentage**
XXX	1	0	00.00%	00.00%	00.00%
Multiple Surgery	**Bilateral Surgery**	**Assistant At Surgery**	**Two Surgeons**	**Team Surgery**	
0	0	0	0	0	

Bilateral Surgery Indicators

- **Bilateral surgery indicators**
  - "0" indicates a unilateral code
    - Modifier 50 is not billable
  - "1" indicates modifier 50 can be appropriate
  - "2" indicates a bilateral code
    - Modifier 50 is not billable
  - "3" indicates primary radiology codes
    - Modifier 50 is billable
  - "9" indicates that the concept does not apply
- Modifier 50 cannot be appended when bilateral indicators are 0, 2 or 9

Bilateral Indicators

- Column 8: Bilateral Surgery (Modifier 50)
  - Indicates services subject to a payment adjustment

Indicator	Description
0	150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100. Payment should be based on the fee schedule amount of $125 since its lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	150 percent payment adjustment for bilateral procedure applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of (a) the total actual charge for both sides, or (b), 150 percent of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

Bilateral Indicators

Indicator	Description
2	150 percent payment adjustment for bilateral does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides, or (b) 100 percent of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100 Payment should be based on the fee schedule amount ($125) since its lower than the total actual charges for the left and right sides ($200).The RVUs are based on the bilateral procedure because (a) the code descriptor specifically states the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or © the procedure is usually performed as a bilateral procedure.
3	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9	Concept does not apply.

NCCI Contractor

- You may submit inquiries about the NCCI program, including those related to NCCI (PTP, MUE, and Add-on Code) edits, in writing via email to NCCIPTPMUE@cms.hhs.gov

  Note: Any submissions made to the NCCI program that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically discarded, regardless of the content

- National Correct Coding Initiative (NCCI) Edits

Redetermination/Reopening

Redetermination

- Redetermination – First level of an appeal
  - NGSConnex
  - Written
- No minimum amount in controversy
- Remittance advice code
  - MA01 – Claim has appeal rights
- Attach supportive medical documentation

Reopening

- Correction to minor, uncomplicated, provider or contractor clerical errors or omissions
  - NGSConnex
  - Telephone
    - TRU line will not process MUE denials
  - Written

Reopening Versus Redetermination

Reopening To correct a claim(s) determination resulting from minor errors	Redetermination (Appeal – First For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
• Mathematical or computational mistake • Inaccurate data entry • Computer errors • Incorrect data items • Transposed procedure or diagnostic codes	• Coverage of furnished items and service • Overpayment determinations • Medical necessity claim denials • Determination on limitation of liability provision

***Reminder:** TRU line does not accept MUE denials, they must be submitted via NGSConnex portal

Reopening

- Assignment of claims (MAC errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician, rendering provider
- Add/change POS changes
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Fee schedule incorrect
- HIC/MBI corrections (MAC error only)
- MSP – Medicare now primary
  - **Note**: MSP claims can only be processed within one year from the date of denial or payment

Reopening

- Patient paid amount (MAC error only)
- **Exception:** If Medicaid or another government entity paid in error, please submit a written request
- Adding/changing a modifier
  - Excluding modifiers AQ, AR, QU, QB, 22, 23, 52, 53, 62, 66, GA, GY and GZ (submit redetermination)
- Reopenings for Minor Errors and Omissions

Contacting the Telephone Reopening Unit

- Please provide
  - Beneficiary's name
  - Medicare number
  - Your name and phone number
  - Provider's full name/PTAN
  - Item or service in question
  - Date(s) of service in question
  - Reason for request

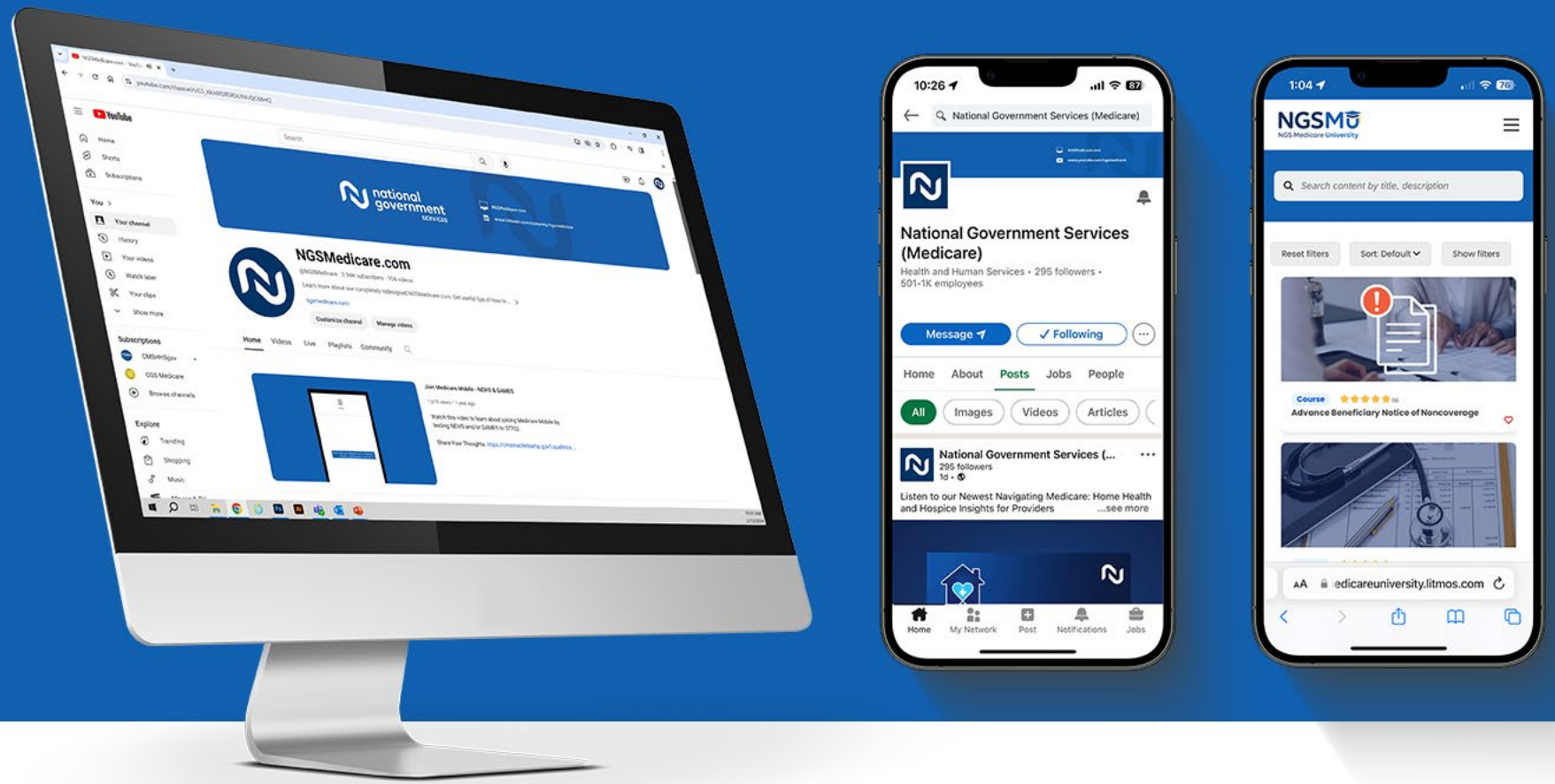
NGSConnex

- Free, secure, web-based application
  - Submit claims
  - Obtain beneficiary eligibility information
  - Submit documents for ADR requests (Medical Review and Select Claims Requests)
  - Initiate and check status of redetermination and reopening requests
  - View duplicate/claim overlaps

Resources

Resources

- MLN® Educational Tool: *How to Use the Medicare National Correct Coding Initiative (NCCI) Tools*
- Medicare Topics
  - Repeat Procedures - Modifiers 76 and 77
  - Proper Use of Modifiers 59 and 91
- MLN® Fact Sheet
  - *Proper Use of Modifiers 59, XE, XP, XS, & XU*
- MLN Matters® *MM11168 Revised: Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes*
- CMS Medically Unlikely Edits
- NGS Medically Unlikely Edits



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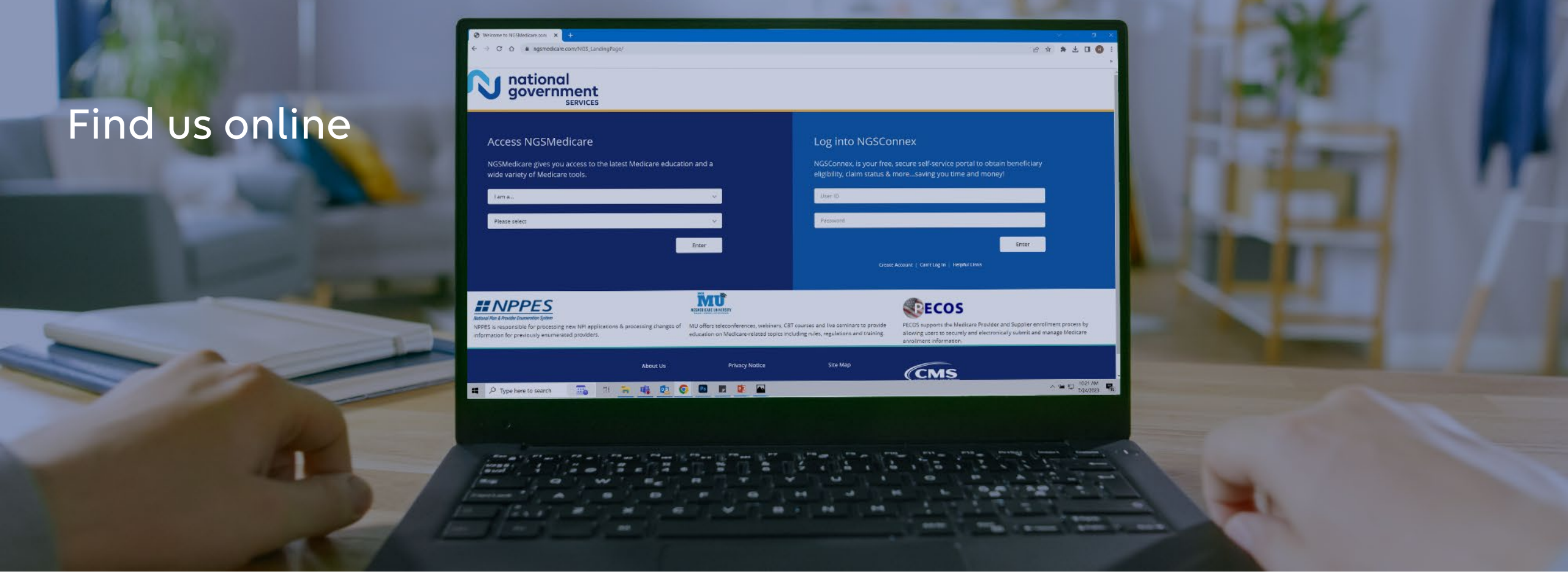

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

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Questions?

Thank you!