



## Physician Services Version

### **KEY CONCEPTS OUTLINE**

#### **Module 6: NCCI, MUEs and Other Must-Know Coding Fundamentals**

##### I. National Correct Coding Initiative ("NCCI") Overview

###### A. What is the NCCI?

1. The NCCI is a CMS initiative intended "to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims." <NCCI Policy Manual, Introduction>
2. The NCCI is maintained by a CMS contractor, Capitol Bridge LLC. The CMS website instructs providers to address concerns regarding specific CCI edits, including Medically Unlikely Edits, to:  
  
National Correct Coding Initiative  
Capitol Bridge LLC  
P.O. Box 907  
Carmel, IN 46082-0907  
Fax #: 317-571-1745
3. NCCI was first implemented by the Medicare carriers in 1996. Subsequently, NCCI was implemented by the intermediaries as a part of the Integrated Outpatient Code Editor ("IOCE") in 2000. <See NCCI Policy Manual, Introduction>
4. NCCI applies only to Medicare Part B claims – it does not apply to hospital inpatient services, or any other services covered under Medicare Part A.

## B. Basis for the NCCI

1. According to the NCCI Manual, the NCCI is developed by CMS for the Medicare program and the most important consideration in developing the edits is CMS Policy. CMS also considers the following:
  - a. The NCCI Policy Manual for Medicare Services;
  - b. CPT and HCPCS Manual code descriptors;
  - c. Coding conventions defined in the CPT Manual;
  - d. Coding guidelines developed by national societies;
  - e. Analysis of standard medical and surgical practice;
  - f. Review of current coding practice; and
  - g. Provider billing patterns. <See NCCI Policy Manual, Introduction>

## C. The NCCI Manual and Edits

1. The NCCI manual contains both correct coding policies and correct coding edits.
2. The NCCI policy manual and edits may be downloaded from the CMS web site at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.
  - a. The NCCI policies and edits are also available from numerous commercial services. However, CMS has designated the CMS web site as the official source. <CMS Frequently Asked Question 11228>

## D. Composition of the NCCI Edits

1. The NCCI consists of three types of edits: Procedure to Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code Edits. <NCCI Policy Manual, Introduction>

## II. Procedure to Procedure (PTP) edits

- A. PTP edits are pairs of CPT or HCPCS Level II codes that are not both separately payable when billed by the same provider for the same beneficiary for the same date of service, unless an appropriate modifier is reported (discussed below). <CMS Frequently Asked Question 11238; NCCI Policy Manual, Introduction>

- 1. When a PTP code pair is reported, without a modifier, the column 1 code processes for payment and the line with the column 2 code is rejected. <CMS Frequently Asked Question 11238>

### B. Obtaining PTP Edits

- 1. The physician specific PTP edits are available in two files posted on the CMS website. The two files contain both the column 1/column 2 edits and the mutually exclusive edits (discussed below). Each file contains roughly half the NCCI edits and is updated quarterly.

### C. Composition of PTP Edits

- 1. Column 1/Column 2" (formerly known as "comprehensive/component") edits
    - a. The Column 1/Column 2 edits are generally designed to prevent unbundling – i.e., separate payment for a service that is considered to be a lesser included component of another more comprehensive service provided at the same session. <CMS Frequently Asked Question 11238>
    - b. For each Column 1/Column 2 Edit, the column 1 code generally has a **higher** payment rate than the column 2 code. This means CMS pays for the code with the **higher** payment amount if the two codes are reported together. <CMS Frequently Asked Question 11234>
  - 2. "Mutually Exclusive" edits
    - a. The "Mutually Exclusive" edits are designed to prevent separate payment for a service that is "mutually exclusive" of another service provided at the same session. The edits consist of procedures which cannot reasonably be performed together based on the code definition or anatomic considerations. <NCCI Policy Manual, Chapter 1(P)>
    - b. The NCCI manual provides the following examples of scenarios where two services "cannot reasonably be done at the same session." <NCCI Policy Manual – Chapter 1(P)>

- (i) The repair of an organ by two different methods. According to the NCCI manual, one repair method must be chosen for the repair.
- (ii) An "initial" service and a "subsequent" service. According to the NCCI manual, it is contradictory for a service to be classified as an initial and a subsequent service at the same time, with the exception of drug administration services.
- c. For each "Mutually Exclusive" Edit, the column 1 code generally has a **lower** payment rate than the column 2 code. This means CMS pays for the code with the **lower** payment amount if both codes are reported together. <CMS Frequently Asked Question 11232>

### 3. Edit Rationales

- a. Effective with the April 2015 release of the PTP edit files, rationales for the PTP edits were released along with each edit, describing the background for that particular edit. Following are examples of those rationales.
  - (i) Standards of medical/surgical practice
  - (ii) HCPCS/CPT procedure code definition
  - (iii) CPT 'separate procedure' definition
  - (iv) Misuse of column two code with column one code
  - (v) Mutually exclusive procedures
  - (vi) Gender-specific (formerly Designation of sex) procedures
  - (vii) Sequential Procedure
- b. Additional definitions for these edit rationales can be found in the NCCI General Correspondence Language and Section-Specific Example Manual, available on the CMS website  
<<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/ncci-correspondence-language-manual.pdf>>
- c. The addition of the information regarding mutually exclusive procedures is important as this information hasn't been made easily available since it was removed from the public files in 2012.

#### D. Modifiers Applied to Procedure-to-Procedure Edits

1. In some cases, appending an NCCI-associated modifier to a column 2 code will “override” (i.e., bypass) the NCCI edit and allow payment for both codes. <CMS Frequently Asked Question 1889>
  - a. There is a “modifier” status indicator assigned to each set of PTP code pairs: <NCCI Policy Manual, Chapter 1 (E)>
    - (i) If the modifier status indicator is “1,” the edit may be overridden by reporting one of the NCCI-associated modifiers on the column 2 code.
      - (a) If the column 2 code is reported without a modifier, the column 2 code will deny.
    - (ii) If the modifier status indicator is “0,” the edit will not be affected by reporting a modifier.
      - (a) If the column 2 code is reported with or without a modifier, the column 2 code will deny. No modifier can override the CCI edit.
    - (iii) If the modifier status indicator is “9,” the edit has been removed from the NCCI and is displayed for historical purposes.
  - b. Exception to Modifier Application
    - (i) Beginning July 1, 2019, CMS will allow modifiers 59, XE, XS, XP, or XU to bypass the NCCI edit, when placed on either the column one or column two codes. < CMS Transmittal 2259>
2. NCCI-Associated Modifiers
  - a. According to CMS, the following modifiers will override an NCCI PTP edit. <NCCI Policy Manual, Chapter 1 (E)>
    - (i) -E1 through -E4 – eyelids
    - (ii) -FA through -F9 – fingers
    - (iii) -LC, -LD, -LM and -RC, -RI - arteries
    - (iv) -LT and -RT – left and right sides
    - (v) -TA through -T9 – toes

- (vi)-24 – unrelated E/M service during post-op period
- (vii)-25 – significant, separately identifiable E/M service
- (viii) -27 – separate and distinct E/M encounter (applicable to outpatient hospital facilities)
- (ix) -57 decision for surgery
- (x) -58 – staged or related procedure
- (xi)-78 – related procedure
- (xii) -79 – unrelated procedure or service
- (xiii) -91 – repeat lab test
- (xiv) -59 – distinct procedural services
  - (a) CMS has published guidance on the use of modifier 59 in addition to the guidance found in CPT and the CPT Assistant.
    - 1. CMS has indicated that modifier 59 is typically only used for procedures performed at:
      - a. Different anatomic sites. <See MLN Matters Article SE1418>
        - i. Treatment of contiguous structures of the same organ do not constitute different anatomic sites. <See MLN Matters Article SE1418>
      - b. During different patient encounters. <See MLN Matters Article SE1418>
  - (b) Additional examples and guidance may be found under the National Correct Coding Initiative Overview page on the CMS website, under the link “Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service” or follow this link:  
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf>
  - (c) CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:  
 <See MLN Matters Article 8863>

1. XE – Separate Encounter, a service that is distinct because it is a separate encounter
  2. XS – Separate Structure, a service that is distinct because it was performed on a separate organ/structure
  3. XP – Separate Practitioner, a service that is distinct because it was performed by a different practitioner
  4. XU – Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service
    - a. Since the X{ESPU} modifiers are more specific versions of the 59 modifier, it would not be appropriate to report it with modifier 59.
    - b. CMS has published information stating that additional education on the use of the 'X' modifiers will continue to be forthcoming, and until that is full established, the use of the modifier 59 is still allowed <See MLN Matters Article SE1503>
3. Use of NCCI-Associated Modifiers
- a. Modifiers should only be appended to HCPCS/CPT codes if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. <NCCI Policy Manual, Chapter 1 (E)>
    - (i) If CMS imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the restrictions are fulfilled. <NCCI Policy Manual, Chapter 1 (E)>

### III. Medically Unlikely Edits

- A. The Medically Unlikely Edits (MUEs) represent the maximum number of units reportable for a HCPCS code by the same provider for the same beneficiary for the same date of service, in most circumstances. <NCCI Policy Manual, Chapter 1 (V)>

- B. CMS published an MUE file containing the MUE limits for some, but not all HCPCS codes. The file is updated quarterly and there is a separate file for practitioner, facility, and DME services. <One Time Notification Transmittal 652>
- C. The MUE file contains a column with the rationale for each of the MUEs. The MUEs are based on the following considerations:
  - 1. Anatomic considerations (e.g. appendectomy);
  - 2. Code descriptions (e.g. a code with the term "initial" in its title);
  - 3. Established CMS policy (e.g. bilateral procedures);
  - 4. Nature of the analyte (e.g. 24 hour urine collection);
  - 5. Nature of the procedure and the amount of time required to perform the procedure (e.g. overnight sleep study);
  - 6. Nature of the item (e.g. wheelchair);
  - 7. Clinical judgment based on input from physicians and clinical coders; and
  - 8. Submitted claims data from a 6 month period. <NCCI Manual, Chapter 1(V)>
- D. The MUE file contains a column indicating whether an MUE will be applied by date of service or by claim line. <MLN Matters Article SE 1422>
  - 1. MUEs Applied by DOS
    - a. All claim lines with the same HCPCS code, regardless of modifier, on the same date of service will be summed and compared to the MUE value. The claim will be denied if the units summed in this way exceed the MUE value. <CMS FAQ 8119>
    - b. For MUEs applied by DOS, CMS has assigned one of 2 MUE Adjudication Indicators (MAI).
      - (i) An MAI of 2 indicates that the edit is based on regulation, policy, or instruction that is inherent in the code descriptor or its applicable anatomy. <MLN Matters Article SE 1422>
      - (a) MACs are bound by MUE values with a MAI of 2 in their determinations and redeterminations. <MLN Matters Article SE 1422>



(ii) An MAI of 3 indicates that the edit is based on clinical information, billing patterns, prescribing instructions, and other information. <MLN Matters Article SE 1422>

(a) If the provider verifies the coding instructions and believes the units in excess of the MUE are correctly coded and medically necessary, the provider may submit an appeal.

## 2. MUEs Applied by Claim Line

a. If a claim line with a HCPCS code subject to an MUE exceeds the MUE value, the line will be denied. <One Time Notification Transmittal 652>

(i) CMS has assigned an MAI of 1 for MUEs applied by claim line.

b. Medically appropriate units of service in excess of an MUE may be reported on a separate line with an appropriate modifier and because each line is edited against the MUE separately, the units on the separate line will process for payment. <See One Time Notification Transmittal 652; NCCI Policy Manual, Chapter 1 (V)>

c. Line item denials for units in excess of an MUE are appealable denials. <One Time Notification Transmittal 652; CMS FAQ 8119>

## IV. Add-on Code Edits

A. An add-on code describes a service that is always performed in conjunction with another primary service and is eligible for payment only when provided with an appropriate primary service. <Medicare Claims Processing Manual Transmittal 2636>

B. CMS implemented a series of add-on code edits effective 4/1/13. <Medicare Claims Processing Manual Transmittal 2636>

1. If an add-on code is reported without the required primary procedure code, the add-on code may not be paid. <Medicare Claims Processing Manual Transmittal 2636>

C. Add-on codes are identified by:

1. Being listed as a Type I, II, or III add-on code by CMS; or

2. Being designated with a "+" symbol or the phrases "each additional" or "list separately in addition to primary procedure" in the CPT Manual. <Medicare Claims Processing Manual Transmittal 2636>

#### D. Add-on Codes are Identified as Type I, II and III

1. Type I add-on codes have a limited number of identifiable primary codes. <Medicare Claims Processing Manual Transmittal 2636>
2. Type II add-on codes do not have a list of acceptable primary codes. MACs must develop a list of acceptable primary codes required for reporting and payment of the add-on code. <Medicare Claims Processing Manual Transmittal 2636>
3. Type III add-on codes have some, but not all, of the acceptable primary codes identified. MACs must develop a list of additional acceptable primary codes for reporting and payment of the add-on code. <Medicare Claims Processing Manual Transmittal 2636>

*Note: January 1, 2022 CMS implemented a new file format for the Add-On Code (AOC) edit file. IT is now a fixed-width test file. CMS has provided a link to the file structure in PDF format.*

#### V. Practical NCCI Issues

##### A. Codes or Units Denied as a Result of NCCI are Provider Liability

1. CMS takes the position that services denied based on an NCCI edit are denied based on incorrect coding, rather than coverage and therefore the service may not be billed to the beneficiary. <See NCCI Policy Manual, Introduction>
  - a. Providers may not issue an ABN and bill the beneficiary for codes or units not paid because of an NCCI edit because non-payment is based on coding rather than medical necessity. <See NCCI Policy Manual, Introduction>

##### B. Do Not Count on the CMS Systems to Serve as Your "Claims Scrubber"

1. In theory, CMS claims processing systems should reject or deny lines or claims that do not conform to NCCI edits, however if the claims system fails and the MAC pays for a service in contradiction to an NCCI edit, the provider may be required to make a repayment.

C. Be Cautious In the Use of Correct Coding Modifiers to Override an NCCI Edit

1. As discussed above, the NCCI modifiers provide a way for practitioners to override particular NCCI edits. However, the modifiers should only be used in a clinically appropriate manner in accordance with CPT and CMS guidelines for modifier usage. The inappropriate use of modifiers could result in an overpayment subjecting the practitioner to an overpayment demand, a false claims action, or worse.

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**INTRODUCTION  
FOR  
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL**

Current Procedural Terminology (CPT) codes, descriptions and other data only are  
copyright **2022** American Medical Association.

CPT® is a registered trademark of the American Medical Association.

Applicable FARS/DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors, and/or related components **aren't**  
assigned by the AMA, **aren't** part of CPT, and the AMA **isn't** recommending their use. The  
AMA **doesn't** directly or indirectly practice medicine or dispense medical services. The  
AMA assumes no liability for the data contained or not contained herein.

**CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory  
Surgical Center (ASC) Payment System.**

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Intro-2

## 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 Physician Fee Schedule (PFS), it was important to assure that uniform payment policies and procedures were followed by all Medicare Administrative Contractors (MACs) so that the same service would be paid similarly in all (A/B MAC processing practitioner service claims) jurisdictions. Accurate coding and reporting of services is a critical aspect of assuring proper payment.

## Purpose

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. 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/or current coding practice.

The NCCI program includes 3 types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code (AOC) 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/supplier reports the 2 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 PTP-associated modifier is also reported.

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/supplier for the same beneficiary on the same date of service. Additional general information concerning NCCI PTP edits and MUEs is discussed in Chapter I.

AOC edits consist of a listing of HCPCS and CPT Add-on Codes with their respective primary codes. An AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

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NCCI PTP edits are used by Medicare claims processing contractors to adjudicate provider/supplier claims for practitioner services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI program was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) 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 (FIs) (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Carriers and FIs are now designated by the CMS as A/B MACs. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in the NCCI program. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims (FIs) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits used for practitioner claims are also used for Ambulatory Surgical Center (ASC) claims.

Prior to January 1, 2012, NCCI PTP edits incorporated into OCE appeared in OCE 1 calendar quarter after they appear in the NCCI program. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. Outpatient hospitals and other providers/suppliers must code correctly even in the absence of NCCI or OCE edits. For example, new Category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in the NCCI program on January 1. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April 1. Hospitals were required to code correctly during the three-month delay.

On January 1, 2007, the CMS incorporated MUEs into the NCCI program. These edits are applicable to claims submitted to Carriers (A/B MACs processing practitioner service claims), A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and FIs (A/B MACs processing outpatient hospital service claims).

Pursuant to Section 6507 of the Patient Protection Affordable Care Act (PPACA), the CMS provided instructions to States for implementation of NCCI methodologies in State Medicaid programs by October 1, 2010. The CMS publishes on its website separate edit files and manuals for the CMS State Medicaid NCCI program methodology. To avoid confusion between the use of the term NCCI for the NCCI program methodology and NCCI PTP edits, the CMS Medicare and Medicaid NCCI programs use the term NCCI PTP to identify NCCI Column One/Column Two edits. The Medicaid NCCI methodology edit files contain edits for HCPCS CPT codes used in the Medicaid program and the Medicare NCCI edit files contain NCCI PTP and MUE edits that are used in the Medicare program.

In this Manual many policies are described using the term “physician.” Unless indicated differently the use of this term does not restrict the policies to physicians only but applies to all

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practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

Providers reporting services under Medicare’s hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare “Internet-Only Manual (IOM”) instructions.

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

Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, the NCCI program policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

NCCI PTP edits are adopted after due consideration of Medicare policies including the principles described in the National Correct Coding Initiative Policy Manual for Medicare Services, HCPCS and CPT Manual code descriptors, CPT Manual coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider/supplier billing patterns. Since the NCCI program is developed by the CMS for the Medicare program, the most important consideration is CMS policy.

Prior to initial implementation of the NCCI program in 1996, the proposed edits were evaluated by Medicare Part B Carrier Medical Directors, representatives of the AMA CPT Advisory Committee, and representatives of other national medical and surgical societies.

The NCCI program undergoes continuous refinement with revised edit tables published quarterly. There is a process to address annual changes (additions, deletions, and modifications) of HCPCS/CPT codes and CPT Manual coding guidelines. Other sources of refinement are initiatives by CMS and comments from CMS, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers/suppliers, consultants, other third-party payors, and other interested parties. Prior to implementing new edits, the CMS generally provides a review and comment period to representative national organizations that may be impacted by the edits. However, there are situations when the CMS thinks that it is prudent to implement edits prior to completion of the review and comment period. CMS evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

## **Policy Manual Background**

The “National Correct Coding Initiative Policy Manual for Medicare Services,” NCCI PTP edits,

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MUEs, and AOC edits have been developed for application to Medicare services billed by a single provider/supplier for a single patient on the same date of service.

**CMS developed** the “National Correct Coding Initiative Policy Manual for Medicare Services” and the edits **to encourage** consistent and correct coding and **reduce** inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers/suppliers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a provider/supplier determines that they have been coding incorrectly, the provider/supplier should contact their MAC about potential payment adjustments.

The “National Correct Coding Initiative Policy Manual for Medicare Services” 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, additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes occur based on changes in technology, standard medical practice, and input from the AMA, specialty societies, other national healthcare organizations (NHOs), Medicare contractor medical directors and staff, providers/suppliers, consultants, etc.

The “National Correct Coding Initiative Policy Manual for Medicare Services” includes an Introduction, and 13 narrative chapters. 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, and Chapter XIII which addresses Category III CPT codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

The “National Correct Coding Initiative Policy Manual for Medicare Services” in general uses paraphrased descriptors of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA’s “Current Procedural Terminology (CPT) Manual” and the CMS’s HCPCS Level II code descriptors for complete descriptors of the codes.

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

The NCCI program undergoes constant refinement, publishing 4 versions annually. Medicare Administrative Contractors (MACs) implement the versions effective January 1, April 1, July 1, and October 1 of each year. Changes in the NCCI program come from 3 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, other NHOs, Medicare contractor medical directors and staff, providers/suppliers, billing consultants, etc.

The CMS sends proposed changes in the NCCI edits to the AMA, national medical/surgical societies, and other NHOs who participate in a review and comment period. The CMS may also specifically seek comment from national medical/surgical societies, providers/suppliers, and

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other NHOs before implementing many types of changes in the NCCI program.

Although national medical/surgical societies and other NHOs generally agree with changes the CMS makes to the NCCI program, the CMS carefully considers all comments. When the CMS decides to proceed with changes in the NCCI program contrary to the comments of national medical/surgical societies or other NHOs, it does so after due consideration of those comments and other information available to the CMS.

An NCCI edit is applicable to the time period for which the edit is effective since the edit is based on coding instructions and practices in place during the edit's effective dates. NCCI PTP, MUE, or AOC edits may be revised for a variety of reasons.

A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of a PTP edit, an MUE value, or an AOC edit for a HCPCS/CPT code by submitting a written request to: [NCCIPTPMUE@cms.hhs.gov](mailto:NCCIPTPMUE@cms.hhs.gov). The written request should include a rationale for reconsideration, as well as a suggestion. Any submissions made to the NCCI contractor that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically discarded, regardless of the content, in accordance with federal privacy rules with which the NCCI Contractor must comply.

Edit revisions may be effective in the next version of the relevant edit file or may be retroactive. A change in an NCCI edit is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive change, Medicare Administrative Contractors (MACs) are not expected to identify claims but may reopen impacted claims that would have payment changes that providers/supplier bring to their attention. In accordance with CMS policy, MACs may reopen impacted claims with potential payment changes brought to their attention by provider/suppliers. Since NCCI edits are auto-denial edits, denials may be appealed. Appeals shall be submitted to MACs, not the NCCI contractor. MACs adjudicating an appeal for a claim denial for a CPT/HCPCS code with an MUE and an MUE Adjudication Indicator (MAI) of "1" or "3" may pay correctly coded and correctly counted medically necessary UOS in excess of the MUE value. In limited circumstances, the CMS may at times issue directions for a mass adjustment when it determines that such an action meets the needs of the program and can occur within its current operational constraints.

The NCCI webpages contain information about the NCCI program including the following.

1. NCCI for Medicare
  - a. Medicare NCCI Policy Manual (Current Version and Archived Manuals)
  - b. Correspondence Language Manual
  - c. Medically Unlikely Edits
  - d. MUE Archive
  - e. Procedure to Procedure Edits
  - f. Add-on Code Edits
  - g. FAQ Library

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- h. How to Use the Medicare National Correct Coding Initiative (NCCI) Tools
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    - i. Medicaid NCCI Policy Manual (Current Version and Archived Manuals)
    - ii. Correspondence Language Manual
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  - e. FAQ Library
  - f. How to Use the Medicaid National Correct Coding Initiative (NCCI) Tools

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

The NCCI program is maintained for the CMS by a contractor. If the user of this manual has concerns regarding the content of the edits or this manual, the user may send an inquiry in writing to the CMS NCCI PTP/MUE email address or address identified on the CMS NCCI webpage.

The CMS makes all decisions about the contents of the NCCI program and this manual. Correspondence from the NCCI contractor reflects CMS's policies on correct coding and the NCCI program.

**Revision Date (Medicare): 1/1/2023**

# **Medicare Claims Processing Manual**

## **Chapter 23 - Fee Schedule Administration and Coding Requirements**

**Table of Contents**  
*(Rev. 11/22, 12 -02-22)*

### **Transmittals for Chapter 23**

Version 02/15/2023  
Check for Updates

Any proposed usage not covered by the current agreement requires the completion of a CPT-CDT-NUBC New Use Application. CMS, then, will negotiate your “new use” with the appropriate association.

## **20.8 - Payment, Utilization Review (UR), and Coverage Information on CMS Annual HCPCS Codes Update File** (Rev. 10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

The file CMS provides for the quarterly update of HCPCS codes contains fields for payment, UR, and coverage information to assist in developing front-end edit screens. Coverage information is not all inclusive, but should be used mainly as a guide in establishing specific review limits. A/B MACs (B) must establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. A/B MACs (B) must assure that their system processes claims in accordance with CMS policies and procedures, including changes that may occur between HCPCS codes updates.

Where CMS determines that nationally uniform temporary codes/modifiers are needed to implement policy/legislation between HCPCS codes updates, the codes/modifiers, definitions and policy are issued as Level II codes/modifiers prefixed with “Q” or “K” or “G.” Questions may arise in updating that require A/B MAC (B) staff to refer to a physician’s or supplier’s pricing history. Therefore, keep an electronic backup of HCPCS codes for the two prior years with linkages to pricing profiles. Perform required computer analysis as necessary.

The HCPCS terminology seldom includes a place of service designation. Where place of service affects pricing, pricing is obtained from the place of service field on the claim record.

A/B MACs (A) and (HHH) also develop editing screens using HCPCS based on payment and coverage policies from CMS. A/B MACs (A) and (HHH) must assure that system claims processing complies with CMS policy and procedures.

## **20.9 - National Correct Coding Initiative (NCCI)**

(Rev. 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)



The CMS developed the National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT manual, CMS 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. An overview of the NCCI program for both the Procedure-to-Procedure (PTP),

Medically Unlikely Edits (MUEs), Add-on Code (AOC) Edits and additional information sources are found on the [CMS NCCI Website](#).

The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual) shall be used by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits.

The purpose of the NCCI PTP edits is to prevent improper payment when incorrect code combinations are reported. The NCCI webpage contains separate tables of edits for physicians / practitioners, outpatient hospital services, and durable medical equipment. Additional information regarding types of tables is available in the How to Use The National Correct Coding Initiative (NCCI) Tools MLN booklet.

The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). The CMS developed MUEs to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service.

An AOC is a HCPCS / CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

CMS posted the Correspondence Language Manual for Medicare Services on the [NCCI Website](#) for use by the Medicare Contractors to answer routine correspondence inquiries about the NCCI PTP and MUE edits. The general correspondence language paragraphs explain the rationale for the edits. The section-specific examples add further explanation to the PTP or MUE edits and are sorted by edit rationale and HCPCS / CPT code section (00000, 10000, 20000, etc.). Please refer to the Introduction of the Correspondence Language Manual for additional guidance about its use.

### **20.9.1 - Correct Coding Modifier Indicators (CCMI) and HCPCS Codes Modifiers**

**(Rev . 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)**

The National Correct Coding Initiative (NCCI) File Formats continue to include a Correct Coding Modifier Indicator (CCMI) for the Column One / Column Two Correct Coding edit file. This indicator determines whether an NCCI PTP-associated modifier causes the code pair to bypass the edit. The CCMI will be either a “0,” “1,” or a “9.” The definitions of each are:

0 = an NCCI PTP-associated modifier is not allowed and will not bypass the edit.

1 = an NCCI PTP-associated modifier is allowed and will bypass the edit.

9 = The use of NCCI PTP-associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator prevents blank spaces from appearing in the indicator field.

**20.9.1.1 - Instructions for Codes With Modifiers (A/B MACs (B) Only)**  
(Rev. 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)

A. General

Medicare Administrative Contractors (MACs) subject all line items for the same beneficiary, same NPI, and same date of service to National Correct Coding Initiative (NCCI) edits.

All line items for the same beneficiary, same NPI, and same date of service shall be subject to NCCI Procedure-to-Procedure (PTP) edits. If the CCMI of a PTP edit is “0”, the Column Two code is not eligible for payment even if an NCCI PTP-associated modifier is appropriately appended to one of the codes. If the CCMI of a PTP edit is “1”, the edit may be bypassed and the Column Two code of the edit may be eligible for payment if an NCCI PTP-associated modifier is appropriately appended to one of the codes. If the 2 codes of a code pair edit have the same NCCI PTP-associated anatomic modifier, the edit will not be bypassed unless an additional NCCI PTP-associated modifier is appended to 1 of the codes indicating the reason to bypass the edit.

The use of modifiers that are not NCCI PTP-associated modifiers shall not bypass an NCCI PTP edit.

NCCI PTP-associated modifiers are the following:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT,  
LC, LD, RC, LM, RI  
Global surgery modifiers: 24, 25, 57, 58, 78, 79  
Other modifiers: 27, 59, 91, XE, XS, XP, XU

B. Modifiers 59 or -X{EPSU}

Modifiers 59 or -X{EPSU} and other NCCI PTP-associated modifiers shall **not** be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. Find further information on modifiers 59 or -X{EPSU} in the Coding Policy Manual available on the CMS website.



Use of modifiers 59 or -X{EPSU} does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifiers -59 or -X{EPSU}.

Modifiers 59 or -X{EPSU} shall not be used with the following codes:

- 77427 Radiation treatment management, 5 treatments
- Evaluation & Management (E&M) services

When a provider or supplier submits a claim for any of the codes specified above with the 59 modifier, the A/B MAC must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.1 above, A/B MACs shall convey additional messaging per instructions in Pub. 100-09, Chapter 6 and Pub. 100-04, Chapter 22.

Examples of appropriate use of modifiers 59 and -X{EPSU} can be found in the Fact Sheet Proper Use of Modifiers 59 & -X{EPSU}.

1. Modifier 59 or –XE are used appropriately when the procedures are performed in different encounters on the same day.
2. Modifier 59 or –XP are used appropriately when the procedures are performed by different practitioners,
3. Modifier 59 or –XS are used appropriately for different anatomic sites during the same encounter only when procedures are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.
4. Other specific appropriate uses of modifiers 59 or -X{EU}
 

There are 3 other limited situations in which 2 services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter.

  - a. Modifier 59 or –XE is used appropriately for 2 services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifiers 59 or –XE that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If 2 timed services are provided in blocks of time that are separate and distinct (i.e., the same time block is not used to determine the unit of service for both codes), modifier 59 may be used to identify the services.
  - b. Modifier 59 or –XU is used appropriately for a diagnostic procedure, which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or on-

surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention; and d) it is not specifically prohibited. If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

c. Modifier 59 or –XU is used appropriately for a diagnostic procedure, which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

5. Modifiers 59 or –X{EPSU} are used inappropriately if the basis for their use is that the narrative description of the 2 codes is different.

### C. Modifier 91

Modifier 91 may be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day when appropriate. If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, (i.e., MAI equal to “1”) appropriate use of CPT modifiers (i.e., 59 or –X{EPSU}, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. This modifier indicates to the Medicare contractors that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier must not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

For example, if a laboratory performs all tests included in a panel of laboratory tests and repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the HCPCS code corresponding to the repeat laboratory test may be reported with modifier 91 appended.

D. Reserved for future use

E. Coding for Noncovered Services and Services Not Reasonable and Necessary

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet: Medicare Advance Written Notices of Noncoverage ICN 006266 found on the CMS website at: [MLN Booklet: Medicare Advance Written Notices of Noncoverage ICN 006266](#).

Use of the A9270

A9270, Noncovered item or service, will not be accepted under any circumstances for services or items billed to A/B MACs. However, in cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the A9270 must continue to be used by suppliers to bill DME MACs for statutorily non-covered items or supplies and items or supplies that do not meet the definition of a Medicare benefit.

Claims Processing Instructions

At A/B MAC and DME MAC discretion, claims submitted using the GY modifier may be auto-denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

Effective for dates of service on and after July 1, 2011, A/B MACs shall automatically deny claim line(s) items submitted with a GZ modifier. A/B MACs shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review.

### **20.9.2 - Reserved for future use**

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

### **20.9.3 – Appeals**

(Rev.10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)



When a request for review is received as a result of an initial determination based on a correct coding initiative edit, and after determining that the reviews were coded correctly, the reviewer must come to the same conclusion as the initial determination (i.e., the review does not result in an increase in payment). If the review determines that a correct coding modifier not submitted with the initial claim could have been appended to either code of an edit code pair, the reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of “1.” If the correct coding initiative edit modifier indicator is a “0,” the reviewer must come to the same conclusion as the initial determination. If the conclusion is the same as the initial determination, the review determination must repeat the generic language that appears in the Medicare Summary Notice (MSN) or remittance advice notice pertaining to the correct coding edit. In addition,

Medicare Administrative Contractors (MACs) must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for MACs in the Medicare Correspondence Language Manual on the CMS NCCI Website.

### **20.9.3.1- Procedure-to-Procedure (PTP) Edits**

(Rev. 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)



All PTP edits have a “Correct Coding Modifier Indicator” (CCMI).

A denial of services due to a Procedure-to-Procedure (PTP) edit is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for Units of Service (UOS) denied based on a PTP.

PTP edits with a CCMI of “0”:

On appeal, if the CCMI is a “0”, and the provider or supplier coded the claim correctly, there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider or supplier. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the National Correct Coding Initiative (NCCI) edit. In addition, Medicare Administrative Contractors (MACs) must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Correspondence Language Manual for Medicare Services.

PTP edits with a CCMI of “1”:

On appeal, if the correct coding initiative edit modifier indicator is a “1”, the reviewer must determine whether the claim was coded correctly. For example, the reviewer should determine whether the provider or supplier reported an incorrect code, a medically unnecessary service, or simply neglected to use a modifier. The reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of “1” and the reviewer determines that an NCCI-associated modifier could have been appended to either code of a correctly coded edit code pair. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the Medicare Summary Notice (MSN) or remittance advice notice pertaining to the NCCI edit. In addition, MACs must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Correspondence Language Manual for Medicare Services.

### **20.9.3.2- Medically Unlikely Edits (MUEs)**

(Rev. 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)



All Healthcare Common Procedure Coding System (HCPCS) codes with Medically Unlikely Edit (MUE) values have an “MUE adjudication indicator” (MAI).

MUEs for HCPCS codes with an MAI of “1”:

MUEs for HCPCS codes with an MAI of “1” will be adjudicated as a claim line edit.

MUEs for HCPCS codes with an MAI of “2”:

MUEs for HCPCS codes with an MAI of “2”: MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because units of service (UOS) on the same date of service in excess of the MUE value would be considered contrary to statute, regulation, or subregulatory guidance. Subregulatory guidance includes clear correct coding policy that is binding on both providers or suppliers and the Medicare Administrative Contractors (MACs). As stated in CR 8853, while Qualified Independent Contractors (QICs) are not bound by subregulatory guidance, they should understand the policy nature of the MAI “2” indicator when considering whether to pay UOS in excess of the MUE value if claim denials based on these edits are appealed.

Limitations created by anatomical or coding restrictions are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in the CMS and National Correct Coding Initiative (NCCI) Policy manuals. For example, it would be contrary to correct coding policy to report more than 1 unit of service for "ventilation assist and management . . . initial day" because such usage could not accurately describe 2 initial days of management occurring on the same date of service as would be required by the code descriptor.

The CMS establishes edits with an MAI of 2 based directly on regulation, statute or subregulatory guidance.

MUEs for HCPCS codes with an MAI of “3”:

MUEs for HCPCS codes with an MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Instructions on MUEs:

- MUEs are set high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that providers or suppliers bring to their attention.
- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to the appropriate MAC not the NCCI contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.
- A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider or supplier actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.” The CMS interprets the notice delivery requirements under Section 1879 of the Social Security Act (the Act) as applying to situations in which a provider or supplier expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI program guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider or supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for UOS denied based on an MUE.
- If a procedure is performed bilaterally and the HCPCS code descriptor does not state that it is a unilateral or bilateral procedure, report bilateral surgical procedures on a single claim line with modifier 50 and one (1) unit of service. For specific instructions for Ambulatory Surgical Centers, refer to Chapter 14, Section 40.5 of the "Medicare Claims Processing Manual" on the CMS website at: [Regulations-and-Guidance.Ch14](#)

When modifier -50 is required by manual or coding instructions, claims submitted with 2 lines or 2 units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and

with the policy in Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" on the CMS website at: [Regulations-and-Guidance.Ch34](#)

Clerical errors (which include minor errors and omissions) may be treated as reopenings.

- Providers or suppliers may change and resubmit their own claims where possible but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR (Integrated Data Repository).
- Providers or suppliers shall use anatomic modifiers (e.g., RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- A/B MACs shall include with the review determination the more detailed explanation of the correct coding initiative edit, which can be found in the standard correspondence language for A/B MACs in the [Correspondence Language Manual for Medicare Services](#).
- MACs shall assign MSN 15.6. CARC 151 with Group Code CO for claims that fail the MUE edits, when the UOS on the claim exceeds the MUE value, and deny the entire claim line(s) for the relevant Healthcare Common Procedure Coding System (HCPCS) code.
- MACs shall assign CARC 236 with Group Code CO and MSN 16.8 for claims that fail the PTP edits, and deny when this procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI program or workers compensation state regulations/fee schedule requirements.

#### **20.9.4 Reserved for future use**

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

##### **20.9.4.1 Reserved for future use**

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

#### **20.9.5 - Adjustments**

(Rev. 1, 10-01-03)

A/B MACs (B) adjust for underpayment if the wrong, lower paying code is paid on the first of multiple claims submitted. If the wrong, higher paying code is paid on the first of

multiple claims submitted, A/B MACs (B) pay the subsequent claim(s) and initiate recovery action on the previously paid claim(s).

### **20.9.6 - Correct Coding Edit (CCE) File Record Format** (Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

The following record layout for the Correct Coding Edit (CCE) File is available to the Shared Systems, A/B MACs (B), and the Regional Offices via Network Data Mover and CMS Data Center.

#### A/B MAC (B)/Shared Systems Record Format

<b>Field</b>	<b>Type</b>	<b>Record Position</b>	<b>Length</b>
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	1	5
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	6	5
Prior Rebundled Code Indicator “*” rebundled prior to 1996 edits “•” rebundled 1/1/1996 or later	Character	11	1
Correspondence Language Reference	Character	12	12
Effective Date (4 position year followed by Julian day)	Numeric	24	7
Deletion Date (4 position year followed by Julian day)	Numeric	31	7
Modifier Indicators “0” No CCE modifier allowed “1” CCE modifier acceptable “9” Use of CCE modifier not specified	Numeric	38	1
Savings Type Indicator Edit “1” CCE “2” Mutually Exclusive	Character	39	1



### **20.9.7 - National Correct Coding Initiative (NCCI) Edits Quarterly Updates**



(Rev. 10878, Issued: 07-15-2021, Effective:08-16-2021; Implementation:08-16-2021)

Medicare Administrative Contractors (MACs) receive quarterly updates to National Correct Coding Initiative (NCCI) edits, indicating the version and the effective date, through a recurring update notification. At this time, the official method for providers or suppliers to receive the National Correct Coding Initiative (NCCI) edits is through the CMS website.

### **30 - Services Paid Under the Medicare Physician's Fee Schedule** (Rev. 1717, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

Following is a general description of services paid under the Medicare Physicians' Fee Schedule (MPFS).

#### **A. Physician's Services**

Effective with services furnished on or after January 1, 1992, A/B MACs (B) pay for physicians' services based on the MPFS. The Medicare allowed charge for such physicians' services is the lower of the actual charge or the fee schedule amount. The Medicare payment is 80 percent of the allowed charge after the deductible is met for most services paid based on the fee schedule. Exceptions to the rule, e.g., services for which deductible is not applicable, are specifically identified for the service where the exception applies.

The Physicians Fee Schedule is used when paying for the following physicians' services.

- Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors;
- Services covered incident to physicians' services other than certain drugs covered as incident to services;
- Physical and occupational therapy, and speech-language pathology services furnished by physical therapists, occupational therapists, and speech-language pathologists in private practices;
- Diagnostic tests other than clinical laboratory tests. See chapter 16 for payment for clinical diagnostic laboratory tests;
- Radiology services; and

Intentionally

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Version 02/14/2023  
Check for Updates

## **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**

MLN Matters Number: MM11168

Related Change Request (CR) Number: 11168

Related CR Release Date: February 15, 2019

Effective Date: July 1, 2019

Related CR Transmittal Number: R2259OTN

Implementation Date: July 1, 2019

### **PROVIDER TYPE AFFECTED**

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This MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

### **PROVIDER ACTION NEEDED**

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CR11168 informs MACs about changes to National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits which consist of column one and column two codes. Make sure that your billing staffs are aware of these changes

### **BACKGROUND**

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Modifiers 59, XE, XS, XP, and XU are among the NCCI-associated modifiers. The Multi-Carrier System (MCS) currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit to bypass the edit. With the implementation of CR 11168, Medicare will allow modifiers 59, XE, XS, XP, or XU on column one and column two codes to bypass the edit.

### **ADDITIONAL INFORMATION**

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The official instruction, CR11168, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2259OTN.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

## DOCUMENT HISTORY

Date of Change	Description
February 19, 2019	Initial article released.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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### Proper Use of Modifier 59

**Note:** This article was revised on January 3, 2018, to conform with the latest Modifier 59 article on the NCCI website. The key update was the addition of information regarding the XE, XS, XP, and XU modifiers.

### Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

### Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same

date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMI, and NCCI-associated modifiers. This manual is available in the download section at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>)

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT Manual* defines modifier 59 as follows:

**“Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers **should NOT be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. **Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that

cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region **does not** constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4.)
- Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6.)

**2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

**3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be “separate and distinct.” The provider should not use modifier 59 for such an edit based on the two codes being “different procedures.” (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. Additionally, there may be



limited circumstances sometimes identified in the *National Correct Coding Initiative Policy Manual for Medicare Services* (available in the downloads section at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>) when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site.

#### 4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

- A. **Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially.** There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)
- B. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.** When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.
- C. **Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.** When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required



during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.



Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

- XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
- XS – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”
- XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- XU – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”

### Examples of Modifier 59 Usage

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 (**Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**):

**Example 1:** Column 1 Code / Column 2 Code - 17000/11100

- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion

- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

**Example 2:** Column 1 Code/Column 2 Code 47370/76942

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

**Example 3:** Column 1 Code/Column 2 Code 93453/76000

- CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

**Example 4:** Column 1 Code / Column 2 Code - 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT codes 11720 and 11055 should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail or the

hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

**Example 5:** Column 1 Code / Column 2 code - 67210/67220

- CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

**Example 6:** Column 1 Code / Column 2 Code - 29827/29820

- CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

**Example 7:** Column 1 Code / Column 2 Code - 93015/93040

- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used.

**Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

**Example 8:** Column 1 Code/Column 2 code - 34833/34820

- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a *CPT Manual* instruction that states: "(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

**Example 9:** Column 1 Code / Column 2 Code - 97140/97530

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes



Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block. **Modifier 59 is used appropriately when two timed procedures are performed in different blocks of time on the same day.**

**Example 10:** Column 1 Code / Column 2 Code - 37220/75710

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation.

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT Manual* defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.**

## Additional Information

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The CMS webpage on the National Correct Coding Initiative Edits is available at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the CMS website. There is a modifier 59 article on this website also.

The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at <http://www.ama-assn.org/ama> on the American Medical Association (AMA) website.

You may want to review MLN Matters® article [MM8863](#) that alerts providers that CMS is establishing four new HCPCS Modifiers to define subsets of Modifier 59, Distinct Procedural Services.

## Document History

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- June 2, 2014 - Initial article released.
- May 27, 2015 - This article was revised to provide a reference to MLN Matters Article [SE1503](#) that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.
- January 3, 2018 - Article updated to conform with latest Modifier 59 article on the NCCI website.

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**Centers for Medicare & Medicaid Services**



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**MLN Matters® Number: MM8863**

**Related Change Request (CR) #: CR 8863**

**Related CR Release Date: August 15, 2014**

**Effective Date: January 1, 2015**

**Related CR Transmittal #: R1422OTN**

**Implementation Date: January 5, 2015**

### **Specific Modifiers for Distinct Procedural Services**

**Note:** This article was revised on May 26, 2015, to provide a reference to MLN Matters® Article [SE1503](#) that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.

### **Provider Types Affected**

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs for services provided to Medicare beneficiaries.

### **Provider Action Needed**



**STOP – Impact to You**

New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier -59 could impact your reimbursement.

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**CAUTION – What You Need to Know**

Change Request (CR) 8863 notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.”

**GO – What You Need to Do**

Make sure your billing staffs are aware of the coding modifier changes.

## Background

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The Medicare National Correct Coding Initiative (NCCI) has Procedure to Procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities. The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR8863 discusses changes to HCPCS modifier -59, a modifier which is used to define a “Distinct Procedural Service.” Modifier -59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The -59 modifier is the most widely used HCPCS modifier. Modifier -59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use to bypass (NCCI).” This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The -59 modifier is

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The -59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

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CR8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:



- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier, when necessitated by local program integrity and compliance needs.

### Additional Information

The official instruction, CR 8863 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf> on the CMS website.

You may also want to review the information on modifier 59, which is available at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf> on the CMS website.

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If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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**2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available** -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the [2015 ICD-10-CM and GEMs](#) web page and [2015 ICD-10-PCS and GEMs](#) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

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## Medically Unlikely Edits (MUE) and Bilateral Procedures

### Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries.

### Provider Action Needed



#### STOP – Impact to You

Claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past. The purpose of this article is to inform providers that MUE changes may now render those claim lines unpayable.



### CAUTION – What You Need to Know

Providers and suppliers, other than ambulatory surgical centers (ASCs), are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and one unit of service (UOS).



### GO – What You Need to Do

Make sure your billing staffs examine their process for filing claims for bilateral procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

## Background

There are several ways that claims for bilateral procedures could be coded, but different methods are only correct in specific situations. The most common methods involve reporting

- a single UOS on one line using the -50 modifier;
- one UOS on each of two lines using modifiers RT and LT; and
- two UOS on a single line with no modifier.

For Medicare claims, when reporting bilateral surgical procedures using codes where the term bilateral is not included in the descriptor, both the "Medicare Claims Processing Manual" and the National Correct Coding Initiative (NCCI) manual specify that these bilateral surgical procedures should be reported using a single UOS and the -50 modifier. The NCCI manual goes on to warn that MUE edits are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently many bilateral procedures have an MUE value of 1, and have had that MUE value for some time.

At the recommendation of the Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per day edits. The MUE Adjudication Indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014 update, published per day edits are identified on the CMS NCCI website (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>) by their MAI value of 2 or 3.

### *MAI of 3*



An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as

- billing patterns;
- prescribing instructions; or

- other information.

It acknowledges that exceptions could occur but they would be sufficiently rare that the abnormally high units of service value should be considered to be a billing error.

Providers should carefully assess any denials based on these edits and consider the denial to be an indication of incorrect reporting due to such things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some provider reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.



### ***MAI of 2***

An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy.

#### **Examples:**

1. The MUE of a “per cervical vertebra” code cannot exceed 7 based on anatomic considerations, that is, the number of cervical vertebrae. The MUE of 7 is therefore inherent in the code descriptor, an integral part of the code set specified for use by Health Insurance Portability & Accountability Act of 1996 (HIPAA).
2. The MUE of a “first 15 minutes” session code for a practitioner cannot exceed 1 since any time beyond that would require a different “subsequent” code, and that limitation is inherent in the code descriptor and its annual incorporation by CMS.

CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.

### ***Request for Reopening of a Claim***

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening to correct its billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing

appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

### **Additional Information**

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If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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