



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE Module 5: Medicare Edit Systems

I. Medicare Code Editor (“MCE”)

A. What is the MCE?

1. The MCE is software used to edit inpatient claims. The MCE identifies claims that require further review before being processed by the GROUPER. <See *Medicare Claims Processing Manual*, Chapter 3 § 20.2.1.A>
 - a. Effective April 1, 2022, the MCE contains 20 edits. The MCE is included in the materials behind the outline. <See *Medicare Claims Processing Manual*, Chapter 3 § 20.2.1; *Medicare Claims Processing Manual* Transmittal 11059>
 - b. For demonstration purposes, an excerpt from the current MCE is included in the materials behind the outline.
 - c. CMS publishes a manual titled “Definitions of Medicare Code Edits” containing a description of each coding edit with the corresponding ICD-10-CM and ICD-10-PCS code lists.

Link: Medicare Code Editor (MCE) Definitions under Medicare-Related Sites - Hospital

II. Integrated Outpatient Code Editor (IOCE)

A. What is the IOCE?

1. The IOCE is software used by the Fiscal Intermediary Shared System (FISS) to edit outpatient claims and assign Ambulatory Payment Classifications (“APCs”). < *Integrated OCE (IOCE) CMS Specifications (IOCE Specifications); IOCE Specifications: 3 Introduction to the IOCE*>

- a. CMS publishes an *IOCE Specifications* document containing descriptions of the edits and logic included in the IOCE. Handout 11 is the current version of the *IOCE Specifications* document.

Link: OCE Specifications under Medicare-Related Sites - Hospital

- B. Each quarter, CMS publishes the IOCE Quarterly Data Files, which include:
 1. An *IOCE Specifications* document containing descriptions of the edits and logic included in the IOCE.
 - a. The Summary of Quarterly Release Modifications, included at the beginning of the document, contains a list of changes to the edits and edit documentation for the quarter.
 2. The Final Summary of Data Changes for each quarter detailing all codes and edits added, deleted, or modified for the quarter.
 3. A folder of "Report-Tables" containing Excel files detailing various data elements for the edits applied through the IOCE software. Applicable lists from these files are included throughout the materials, with instructions for finding them in the files for the purpose of updating them in subsequent quarters.
 - a. Note: The excel files have version columns to indicate the timeframes the edits or information apply. The "LO_VERSION" indicates the first applicable quarter and the "HI_VERSION" indicates the last applicable quarter. For example, Version 82 corresponds to the January 2021 quarter.
 4. A folder of "Report-Table-Difference" containing Excel files detailing additions, deletions, and modifications to various data elements for the edits applied through the IOCE software.
- C. Applicability to hospital outpatient claims
 1. All hospital outpatient Part B claims are processed through the IOCE, including certain non-OPPS hospitals. <See Handout 11 – *IOCE Specifications: 4 Processing that Applies to Both OPPS and Non-OPPS Claims*>
 - a. Part B claims include outpatient services billed on TOB 085X and certain inpatient services billed on TOB 012X (discussed in a later module).

D. IOCE Edits

1. In general, the edits are driven by the ICD-10-CM diagnosis codes, the HCPCS codes, and any modifiers reported on the claim. <See Handout 11 – *IOCE Specifications: 3 Introduction to the IOCE*>

E. Why do hospitals need to know anything about the IOCE?

1. The *IOCE Specifications* sometimes answer billing/coding questions that are not clearly answered anywhere else.
2. For more information on the application of IOCE edits to CAHs, see Handout 11 -- *IOCE Specifications: 6.4 IOCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2]*.

III. 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. NCCI applies only to Medicare Part B claims. It does not apply to services covered under Medicare Part A.
3. For more information on the application of NCCI edits to CAHs, see Handout 11 -- *IOCE Specifications: 6.4 IOCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2]*.

Concerns regarding specific NCCI edits, including MUEs, should be addressed to:
 National Correct Coding Initiative
 Email: NCCIPTMUE@cms.hhs.gov
 P O Box 368
 Pittsboro, IN 46167
 Fax #: 317-571-1745

B. Types of 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; Medicare Claims Processing Manual, Chapter 23 § 20.9*>

C. Basis for the NCCI Edits

1. According to the *NCCI Policy Manual*, the NCCI is developed by CMS for the Medicare program and the most important consideration in developing the edits is CMS Policy.
2. 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. <*NCCI Policy Manual*, Introduction>

D. *NCCI Policy Manual* and Edits

1. The *NCCI Policy Manual* and edits may be downloaded from the NCCI web site. Scroll to the bottom of the page to download a guide entitled "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools". Handout 12 is a copy of the recent version of the guide.

Link: National Correct Coding Initiative under Medicare-Related Sites – General
 Use the links on the left navigation area to go to the current NCCI Policy Manual.
 Use the links on the left navigation area to go to the PTP, MUE and Add-on edits.
 Use the links on the left navigation area to go to PTP and MUE quarterly updates.

IV. 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). <*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 codes is rejected.
 <See Handout 11 – *IOCE Specifications: 6.2 Edit Descriptions and Reason for Edit Generation Table*>

B. Obtaining PTP Edits

1. The hospital specific PTP edits are available in four files posted on the CMS website. The four files contain both the column 1/column 2 edits and the mutually exclusive edits (discussed below). Each file contains roughly one quarter of the NCCI edits and is updated quarterly.

Link: National Correct Coding Initiative (NCCI) –under Medicare-Related Sites - General

C. Composition of PTP Edits

1. “Column 1/Column 2” 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). <NCCI Policy Manual, Introduction>
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, Introduction>

Tip: The column 1 code of a mutually exclusive pair is the lower weighted (i.e., lower paying) code. If grouper software indicates a mutually exclusive edit, it is important to recode the case to ensure the correct code is reported, which in many cases is the higher weighted column 2 code.

- b. The *NCCI Policy 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 Policy Manual*, one repair method must be reported for the repair.
 - ii. An “initial” service and a “subsequent” service. According to the *NCCI Policy Manual*, it is contradictory for a service to be classified as an initial and a subsequent service at the same time, except for drug administration services.

D. Modifiers Applied to Procedure-to-Procedure Edits

1. In some cases, appending an NCCI modifier to a column 2 code will “override” (i.e., bypass) the NCCI edit and allow payment for both codes. <NCCI Policy Manual, Chapter 1; Medicare Claims Processing Manual, Chapter 4 § 20.9.1.1 A>
 - a. A Correct Coding Modifier Indicator (CCMI) is assigned to each set of PTP code pairs. <See Handout 11 – IOCE Specifications: 6.2 Edit Descriptions and Reason for Edit Generation Table; Medicare Claims Processing Manual, Chapter 23 § 20.9.1>
 - i. If the CCMI is a “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, edit 40 of the IOCE rejects the line with the column 2 code.
 - ii. If the CCMI is a “0,” the edit will not be affected by reporting one of the NCCI-associated modifiers.
 - a) If the column 2 code is reported with or without a modifier, edit 20 of the IOCE rejects the line with the column 2 code.
 - iii. If the CCMI is a “9,” the edit has been removed from the NCCI and is displayed for historical purposes.

Case Study 1

Facts: Ms. Percy, a Medicare patient, presented to a CAH’s outpatient clinic for excision of a swelling on her left eyelid (CPT code 67800) that was blocking her vision. During the procedure, the physician also performed an incisional biopsy of the eyelid skin (CPT code 67810) and documented the biopsy was part of the excision of the cyst. The following PTP edit exists:

Column 1	Column 2	Modifier Status Indicator
67800	67810	1

- How should these two procedures be reported?

2. NCCI Modifiers

- a. According to CMS, the following modifiers will override an NCCI PTP edit.
<See Handout 10 - *IOCE Specifications: 4.1 National Correct Coding Initiative (NCCI) Edits; NCCI Policy Manual, Chapter 1 (E); Medicare Claims Processing Manual, Chapter 23 § 20.9.1.1*>
- 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 (identified in the IOCE but inapplicable to hospital reporting)
 - vii. -25 – significant, separately identifiable E/M service
 - viii. -27 – separate and distinct E/M encounter
 - ix. -57 – decision for surgery (identified in the IOCE but inapplicable to hospital reporting)
 - x. -58 – staged or related procedure
 - xi. -59 – distinct procedural services
 - a) Modifier -59 should only be used if no other more specific modifier is appropriate. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*>
 - b) CMS established the -X{EPSU} modifiers to provide greater reporting specificity in situations where modifier -59 was previously reported and may be used in lieu of modifier -59 whenever possible. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*>
 - 1) -XE: separate encounter. A service that is distinct because it occurred during a separate encounter on the same date of service.
 - 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.
- xii. -78 – related procedure
 - xiii. -79 – unrelated procedure or service
 - xiv. -91 – repeat lab test
3. CMS published updated guidance on the use of modifier -59 and the -X{EPSU} modifiers in addition to the guidance found in the *CPT Manual* and *CPT Assistant*. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{EPSU}*; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.1.1>

Tip: CMS guidance appears to indicate the X modifiers should be used if the provider is certain they fit the coding scenario, otherwise modifier -59 would be used. While their use is not required, CMS guidance indicates they should be used when they can be appended with certainty.

- a. CMS has indicated that modifiers -59 or -XS are typically only used for procedures performed at procedures on different anatomic sites not ordinarily performed or encountered on the same day.
 - i. Treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites.
 - a) CMS has indicated that modifiers -59 or -XE are typically only used for procedures performed during different patient encounters on the same day.
 - 1) Modifiers -59 or -XE should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.
 - 2) An encounter is defined as direct person contact between the patient and a physician or other person authorized to order or furnish services for diagnosis or treatment of the patient. <*Medicare Claims Processing Manual*, Chapter 2 § 90.6>

- 3) An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. An episode of care may last more than one calendar day. <National Correct Coding Initiative Policy Manual, Chapter XI, Section J, Subsection 8>
- b) CMS has provided 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 if provided during the same encounter. <See *MLN Fact Sheet: Proper Use of Modifiers 59 & -X{ESPU}*>
- 1) Modifiers -59 or -XE can be used when two services described by timed codes are provided during the same encounter and they are performed sequentially (i.e., one service is completed before the subsequent service begins).
 - 2) Modifiers -59 or -XU can be used when a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure only if the diagnostic procedure clearly provides the information needed to make a decision to proceed with the therapeutic procedure.
 - 3) Modifiers -59 or -XU can be used when a diagnostic procedure occurs subsequent to a completed therapeutic procedure only if the diagnostic procedure is not an otherwise inherent part of the therapeutic procedure.

4. Use of NCCI 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. Documentation in the medical record must satisfy the criteria required by any NCCI PTP-associated modifier that is used. <NCCI Policy Manual, Chapter 1 (E); see MLN1783722>

Case Study 2

Facts: Mr. Henderson was badly injured because of a fall at his home. Among other problems, he had a penetrating wound of his left arm and a deep hematoma on his right shoulder. He was rushed to outpatient surgery where the surgeon explored the arm wound (CPT code 20103) and drained the shoulder hematoma (CPT code 23030). The following PTP edit exists:

Column 1	Column 2	Modifier Status Indicator
23030	20103	1

- How should these two procedures be reported?

V. Medically Unlikely Edits

- A. 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); Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2>
- B. CMS publishes 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. <NCCI Policy Manual, Chapter 1 (V)>

Link: Medically Unlikely Edits Information under Medicare-Related Sites – General

- 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;
8. Prescribing information based on FDA labeling and off label information; and
9. Submitted claims data from a 6-month period. <NCCI Policy Manual, Chapter 1(V)>

D. MUE Adjudication Indicator (MAI)

1. The MUE file contains a MAI indicating whether an MUE will be applied by date of service or by claim line. <See *Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2*>
2. MUEs applied by claim line – MAI of 1
 - a. If a claim line with a HCPCS code with a MAI of 1 exceeds the MUE value, the line will be denied. <See *Medicare One Time Notice Transmittal 1421*>
 - b. Medically appropriate units of service in excess of an MUE may be reported on a separate line with an appropriate modifier. Each line is edited against the MUE separately so the units on the separate line will process for payment. <NCCI Policy Manual, Chapter 1 (V)>
 - c. Line item denials for units in excess of an MUE are appealable. <See *Medicare One Time Notice Transmittal 1421*>
3. MUEs applied by DOS – MAI of 2 or 3
 - a. All claim lines on the same date of service with the same HCPCS code with a MAI of 2 or 3, regardless of modifier, will be summed and compared to the MUE value. The claim lines will be denied if the units summed in this way exceed the MUE value. <See *Medicare One Time Notice Transmittal 1421*>
 - i. Claim lines are summed on the claim being edited and all prior paid claims with the same date of service. <See *Medicare One Time Notice Transmittal 1421*>

- b. A MAI of 2 indicates that the edit is based on regulation, policy or instruction that is inherent in the code descriptor. <See *Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2*>
 - i. MACs are bound by MUE values with a MAI of 2 in their determinations and redeterminations.
 - c. A MAI of 3 indicates that the edit is based on clinical information, billing patterns, prescribing instructions and other information. <See *Medicare One Time Notice Transmittal 1421; Medicare Claims Processing Manual, Chapter 23 § 20.9.3.2*>
 - i. If the provider verifies the coding instructions and the units are correctly coded and medically necessary, the provider may submit an appeal.
4. MUEs applied to CAHs billing under Method II
- a. The facility MUEs will be applied once to units of service reported with any applicable hospital outpatient revenue codes, except 096X, 097X and 098X. <See *Medicare One Time Notice Transmittal 1421*>
 - b. The practitioner MUEs will be applied once to units of service reported with revenue codes 096X, 097X and 098X and **without** modifiers -AS, -80, -81, or -82 (i.e., primary surgeon). <See *Medicare One Time Notice Transmittal 1421*>
 - c. The practitioner MUEs will also be applied once to units of service reported with revenue codes 096X, 097X and 098X and **with** modifiers -AS, -80, -81, or -82 (i.e., assistant surgeon). <See *Medicare One Time Notice Transmittal 1421*>

Case Study 3

Facts: On April 1st the CAH performed the same lab test three times for a patient who was receiving observation services. Prior to billing, the CAH determined all three lab tests were medically necessary according to the physician's order and related documentation. The line item for the lab tests was denied stating it exceeded the maximum number of units for the HCPCS code. After researching further, the CAH identified that the MUE value for the HCPCS code is 2 and the edit has a MAI of 3.

- Could the CAH have received payment for all three tests if it had initially reported the units in excess of the MUE value on a separate line with a modifier?

VI. Add-on Code Edits

- A. An add-on code describes a service always performed in conjunction with another primary service. An add-on code may not be reported unless the code for the primary service is also reported on the claim. <Medicare Claims Processing Manual Transmittal 2636; Medicare Claims Processing Manual, Chapter 23 § 20.9>
1. Add-on codes are designated with a "+" symbol or the phrases "each additional" or "list separately in addition to the primary procedure" in the CPT Manual.
- B. If an add-on code is reported without the required primary procedure code on the same day or the day before, the line with the add-on code will trigger a line item denial. <See *IOCE Specifications*, Section 4.2 (Supplement)>
1. Exception for Drug Administration Codes
 - a. The add-on code edits for drug administration add-on codes are applied by claim. The drug administration add-on codes trigger a line item denial only if the associated primary procedure code is not reported on the same claim, rather than the same day or day before. <See Handout 11 - *IOCE Specifications: 4.2 Add-on Code Edits*>
 - b. The list of drug administration add-on codes is available in the IOCE Quarterly Data Files, Data Table Reports folder, "DATA_HCPCS" file, column DD "ADDON_DRUG_ADMIN". The current quarterly file is available on the IOCE homepage and the current list is included in the materials behind the outline. <See Handout 11 - *IOCE Specifications: 4.2 Add-on Code Edits*>
- C. Add-on code edits applied to CAHs billing under Method II
1. If a CAH submits a claim containing both facility services and professional services reported with revenue codes 096X, 097X, and 098X, add-on code editing is applied for the professional services separately from the facility services. <See Handout 11 - *IOCE Specifications: 4.2 Add-on Code Edits*>
- D. Prior to 2022, CMS published an Excel file containing the add-on code edits and updated the edits in January and on a quarterly basis as necessary. Beginning 2022, CMS only makes the file available as a "fixed-width text file". <CMS.gov, "Add-on Code Edits" website>

Link: Add-on Code Edits (NCCI) under Medicare-Related Sites – General

E. Three Types of Add-on Code Edits

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, 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 >*

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Check for Updates

Case Study 4

Facts: Mrs. Stewart presents to the CAH's outpatient surgical department for a neuroplasty procedure to treat carpal tunnel syndrome (CPT code 64721). During the procedure, the surgeon performed neurolysis using the operating microscope (CPT code 64727). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990. The following PTP edit and Type I Add-on code edit exists:

Column 1	Column 2	Modifier Status Indicator
64721	69990	0

Add-on Code	Primary Codes
64727	64702-64726

- How should these three procedures be reported?

VII. Practical NCCI Issues

A. Codes or Units Denied Because of an NCCI Edit 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. <*NCCI Policy Manual*, Introduction; *Medicare Claims Processing Manual*, Chapter 23 § 20.9.3.1 and 20.9.3.2>
 - 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. <*Medicare Claims Processing Manual*, Chapter 23 § 20.9.3.1 and 20.9.3.2>

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.

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: Ms. Percy, a Medicare patient, presented to a CAH's outpatient clinic for excision of a swelling on her left eyelid (CPT code 67800) that was blocking her vision. During the procedure, the physician also performed an incisional biopsy of the eyelid skin (CPT code 67810) and documented the biopsy was part of the excision of the cyst. The following PTP edit exists:

Column 1	Column 2	Modifier Status Indicator
67800	67810	1

- How should these two procedures be reported?

Analysis: Only 67800 should be reported. According to the NCCI edit, the biopsy (67810) is bundled into the excision (67800) and should not be reported separately unless it is a distinct procedure (e.g., performed on a different anatomic site). The physician documented the biopsy was part of the excision so it would be inappropriate to report it separately.

Case Study 2

Facts: Mr. Henderson was badly injured because of a fall at his home. Among other problems, he had a penetrating wound of his left arm and a deep hematoma on his right shoulder. He was rushed to outpatient surgery where the surgeon explored the arm wound (CPT code 20103) and drained the shoulder hematoma (CPT code 23030). The following PTP edit exists:

Column 1	Column 2	Modifier Status Indicator
23030	20103	1

- How should these two procedures be reported?

Analysis: Both procedures should be reported and modifier -59 or -XS would be appended to 20103 because the procedure involved a separate anatomic site. Failure to report the modifier -59 or -XS on the column 2 code would cause the code to reject, resulting in underpayment.

Case Study 3

Facts: On April 1st, the CAH performed the same lab test three times for a patient who was receiving observation services. Prior to billing, the CAH determined all three lab tests were medically necessary according to the physician's order and related documentation. The line item for the lab tests was denied stating it exceeded the maximum number of units for the HCPCS code. After researching further, the CAH identified that the MUE value for the HCPCS code is 2 and the edit has a MAI of 3.

- Could the CAH have received payment for all three tests if it had initially reported the units in excess of the MUE value on a separate line with a modifier?

Analysis: No. The MAI of 3 indicates the edit is applied by date of service. Billing units in excess of the MUE on a separate line with a modifier will not allow the additional units to be paid initially. Based on the MAI of 3, the CAH may appeal the denial after confirming the units were coded correctly and were medically necessary.

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Case Study 4

Facts: Mrs. Stewart presents to the CAH's outpatient surgical department for a neuroplasty procedure to treat carpal tunnel syndrome (CPT code 64721). During the procedure, the surgeon performed neurolysis using the operating microscope (CPT code 64727). Microsurgical techniques requiring the use of the operating microscope are described by CPT code 69990. The following PTP edit and Type I Add-on code edit exists:

Column 1	Column 2	Modifier Status Indicator
64727	69990	0

Add-on Code	Primary Codes
64727	64702-64726

- How should these three procedures be reported?

Analysis: The hospital should report 64721 and 64727. The applicable PTP edit will reject 69990 if it is reported with 64727. The provider must report the neuroplasty code 64721 along with the neurolysis 64727. The applicable add-on code edit requires the primary code for the neuroplasty be reported with the neurolysis or the claim will be returned to the provider.

Version 03/03/2023
Check for Updates

The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include correct diagnosis and procedure coding, coverage, and clinical edits.

Built into the MCE, which is the first portion of the Grouper program, are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review may be conducted by the A/B MACs (A), using medical records and the approved claim.

Grouper Program

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

Pricer Program

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary who's benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below. Hospitals and hospital claims in multiple geographic areas may obtain a Pricer from

National Technical Institute
U.S. Department of Commerce
NTIS
Springfield, VA 22161.

Hospitals may also download a PC Pricer that will process one record at the time from the CMS Web site at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html>.

20.2.1 - Medicare Code Editor (MCE) (Rev. 3504, Issued: 04-28-16, Effective: 10-01-16, Implementation: 10-03-16)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

 The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits** - Examines a record for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.
- **Coverage Edits** - Examines the type of patient and procedures performed to determine if the services were covered.
- **Clinical Edits** - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).
- Where no Medicare payment is being made. Where partial payment is made, editing is required.
- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.

The MCE needs the following data elements to analyze the bill:

- Age;
- Sex;
- Discharge status;
- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the bill as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the A/B MAC (A) considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes. **Applicable** ICD-10-CM and ICD-10-PCS codes will be provided as part of the annual updates when ICD-10 is implemented.



1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the bill to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

Proper Use of Modifiers 59 & –X{EPSU}

Introduction

This fact sheet educates physicians and other providers on proper use of modifiers 59 and –X{EPSU} and gives information on:

- Definition of modifiers 59, XE, XP, XS, and XU
- Appropriate and inappropriate use of these modifiers
- Examples of appropriate and inappropriate use

Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you shouldn't report certain HCPCS or CPT codes together either in all situations or in most situations. These edits allow the following:

- For NCCI PTP-associated edits that have a Correct Coding Modifier Indicator (CCMI) of "0," never report the codes together by the same provider for the same beneficiary on the same date of service. If you do report the codes together on the same date of service, the Column One code is eligible for payment and Medicare denies the Column Two code.
- For NCCI PTP-associated edits that have a CCMI of "1," you may report the codes together only in defined circumstances by using specific NCCI PTP-associated modifiers.

Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, [Chapter 1](#), for general information about the NCCI program, NCCI PTP-associated edits, CCMI, and NCCI PTP-associated modifiers.

One purpose of NCCI PTP-associated edits is to prevent payment for codes that report overlapping services except where the services are "separate and distinct." Modifier 59 is an important NCCI PTP-associated modifier that providers often use incorrectly.

This fact sheet will help you use this modifier correctly.

Definition of Modifiers 59, XE, XP, XS, and XU

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 (Evaluation/Management) 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.”

Don't use modifiers 59, -X{EPSU} and other NCCI PTP-associated modifiers to bypass an NCCI PTP edit unless the proper criteria for use of the modifiers are met. Medical documentation must satisfy the required criteria.

Effective January 1, 2015, XE, XS, XP, and XU are valid modifiers. These modifiers give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible. (Only use modifier 59 if no other more specific modifier is appropriate.)

CMS allows the modifiers 59 or -X{ESPU} on Column One or Column Two codes (see the related transmittal at [CR11168](#)).

We define these modifiers as follows:

- XE – “Separate Encounter, a service that is distinct because it occurred during a separate encounter.” Only use XE 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”

Appropriate & Inappropriate Use of These Modifiers

1. Using modifiers 59 or -XS properly for different anatomic sites during the same encounter only when procedures which aren't 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

Modifiers 59 or –XS are for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that:

- Are performed at different anatomic sites,
- Aren't ordinarily performed or encountered on the same day, and
- Can't be described by one of the more specific anatomic NCCI PTP-associated modifiers – that is, RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3 below.)

From an NCCI program perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. We created NCCI edits to prevent the inappropriate billing of lesions and sites that aren't considered separate and distinct. The treatment of contiguous structures in the same organ or anatomic region doesn't generally 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 below.)
- Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. (See example 5 below.)

2. Only use modifiers 59 or -XE if no other modifier more properly describes the relationship of the 2 procedure codes.

Another common use of modifiers 59 or –XE is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that can't be described by one of the more specific NCCI PTP-associated modifiers – that is, 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7 below.)

3. Don't use modifiers 59 or –XU just because the code descriptors of the 2 codes are different.

One of the common misuses of modifier 59 relates to the part of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the 2 codes of a code pair edit describe different procedures, even though they may overlap. Don't report the 2 codes together if they're performed at the same anatomic site and same patient encounter, because they aren't considered "separate and distinct." Don't use modifiers 59 or –XU to bypass a PTP edit based on the 2 codes being "different procedures." (See example 8 below.)

However, if you perform 2 procedures at separate anatomic sites or at separate patient encounters on the same date of service, you may use modifiers 59 or –X{ES} to show that they're different procedures on that date of service. Also, there may be limited circumstances sometimes identified in the [National Correct Coding Initiative Policy Manual](#) for Medicare services when you may report the 2 codes of an edit pair together with modifiers 59 or –X{ES} when performed at the same patient encounter or at the same anatomic site.

4. Other specific proper uses of modifiers 59 or -XE

There are 3 other limited situations where you may report 2 services as separate and distinct because they're separated in time and describe non-overlapping services even though they may occur during the same encounter.

- A. **Using modifiers 59 or -XE properly for 2 services described by timed codes provided during the same encounter only when they are performed one after another.** There's an appropriate use for modifier 59 that's applicable only to codes for which the unit of service is a measure of time (two examples are: per 15 minutes or per hour). If you provide 2 timed services in time periods that are separate and distinct and aren't mingled with each other (that is, you complete one service before the next service begins), you may use modifiers 59 or -XE to identify the services. (See example 9 below.)
- B. **Using modifiers 59 or -XU properly for a diagnostic procedure which is performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.** When a diagnostic procedure is performed before a surgical procedure or non-surgical therapeutic procedure and is the basis on which you decide to perform the surgical procedure, you may consider that diagnostic procedure to be a separate and distinct procedure as long as it:
- Occurs before the therapeutic procedure and isn't mingled with services the therapeutic intervention requires;
 - Provides clearly the information needed to decide whether to proceed with the therapeutic procedure; and
 - Doesn't constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10 below.)

If the diagnostic procedure is an inherent component of the surgical procedure, don't report it separately.

- C. **Using modifiers 59 or -XU properly for a diagnostic procedure which occurs after a completed therapeutic procedure only when the diagnostic procedure isn't a common, expected, or necessary follow-up to the therapeutic procedure.** When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure as long as it:
- Occurs after the completion of the therapeutic procedure and isn't mingled with or otherwise mixed with services that the therapeutic intervention requires, and
 - Doesn't 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, don't report it separately.

Use of modifiers 59 or –X{EPSU} don't require a different diagnosis for each HCPCS or CPT coded procedure. On the other hand, different diagnoses aren't adequate criteria for use of modifiers 59 or –X{EPSU}. The HCPCS or CPT codes remain bundled unless you perform the procedures at different anatomic sites or separate patient encounters or meet one of the other 3 scenarios described by A, B, or C above.

Examples of Appropriate & Inappropriate Use

Example 1: Column 1 Code/Column 2 Code - 11102/17000

- CPT Code - 11102 - Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
- CPT Code - 17000 - Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

You may report modifiers 59 or -XS with either the Column 1 or Column 2 code if you did the procedures at different anatomic sites on the same side of the body and a specific anatomic modifier isn't applicable. If you did the procedures on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers. Don't use modifiers 59 or -XS.

The use of modifier 59 or -XS is appropriate for different anatomic sites during the same encounter only when procedures (which aren't 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 2: Column 1 Code/Column 2 Code - 47370/76942

- CPT Code - 47370 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
- CPT Code - 76942 - Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Don't report CPT code 76942 with or without modifiers 59 or –X{EPSU} if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure 47370. Only report 76942 with modifiers 59 or –X{EPSU} 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 injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code - 76000 - Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time

Don't report CPT code 76000 with or without modifiers 59 or –X{EPSU} for fluoroscopy in conjunction with a cardiac catheterization procedure. You may report modifier 59 or –XU 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); 1 to 5

Don't report CPT codes 11720 and 11055 together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Don't use modifiers 59 or –X{EPSU} if you debride a nail on the same toe on which you pare a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint. You may report modifier 59 or –XS with code 11720 if you debride 1 to 5 nails and you pare a hyperkeratotic lesion on a toe other than 1 with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which you debride a nail.

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

Don't report CPT code 67220 with or without modifier 59 or –X{EPSU} if you perform both procedures 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

Don't report CPT code 29820 with or without modifiers 59 or –X{EPSU} if you perform both procedures on the same shoulder during the same operative session. If you perform the procedures on different shoulders, use modifiers RT and LT, not modifiers 59 or –X{EPSU}.

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 supervision, interpretation and report
- CPT Code - 93040 - Rhythm ECG, 1-3 leads; with interpretation and report

You may report modifiers 59 or –XE if you interpret and report the rhythm ECG at a different encounter than the cardiovascular stress test. If you interpret and report a rhythm ECG during the cardiovascular stress test encounter, don't report 93040 with or without modifier 59. You may report modifiers 59 or –XE when you interpret and report the procedures 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, don’t report them together for the same side. Don’t add modifiers 59 or –X{EPSU} to either code to report 2 procedures for the same side of the body. If you performed 2 procedures on different sides of the body, you may report them with modifiers LT and RT as appropriate. However, modifiers 59 or –X{EPSU} are inappropriate if the basis for their use is that the narrative description of the 2 codes is different.

Example 9: Column 1 Code/Column 2 Code - 97140/97750

- CPT Code - 97140 - Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- CPT Code - 97750 - Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

You may report modifier 59 if you perform 2 procedures in distinctly different 15 minute time blocks. For example, you may report modifier 59 if you perform 1 service during the initial 15 minutes of therapy and you perform the other service during the second 15 minutes of therapy. As another example, you may report modifier 59 if you split the therapy time blocks by performing manual therapy for 10 minutes, followed by 15 minutes of physical performance test, followed by another 5 minutes of manual therapy. Don’t report CPT code 97550 with modifier 59 if you perform 2 procedures during the same time block. You may report modifier 59 when you perform 2 timed procedures in 2 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

You may report modifier 59 or –XU with CPT code 75710 if you haven’t already performed a diagnostic angiography and you base the decision to perform the revascularization on the result of the diagnostic angiography. The CPT Manual defines additional circumstances under which you may report diagnostic angiography with an interventional vascular procedure on the same artery. You may report modifier 59 or –XU for a diagnostic procedure performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Resources

- [National Correct Coding Initiative webpage](#)

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1422	Date: August 15, 2014
	Change Request 8863

SUBJECT: Specific Modifiers for Distinct Procedural Services

I. SUMMARY OF CHANGES: CMS is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.”

EFFECTIVE DATE: January 1, 2015

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 5, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1422	Date: August 15, 2014	Change Request: 8863
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SUBJECT: Specific Modifiers for Distinct Procedural Services

EFFECTIVE DATE: January 1, 2015

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 5, 2015

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is establishing four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.” Currently, providers can use the -59 modifier to indicate that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled. Because it can be so broadly applied, some providers incorrectly consider it to be the “modifier to use to bypass National Correct Coding Initiative (NCCI)”, it is the most widely used modifier. It is also associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases. CMS is concerned by this pattern of abuse because such behavior siphons off funds that should be available to legitimate and compliant providers and additionally unnecessarily increases beneficiary costs.

The NCCI has Procedure to Procedure edits to prevent unbundling and 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 so it would be inappropriate to report it separately. Separate reporting would trigger a separate payment and would constitute double billing.

However it is recognized that in specific limited circumstances the duplicate payment could be sufficiently small or would not exist, so that separate payment would be indicated. Edits are defined by NCCI as optional and bypassable or as permanent and non-bypassable. Modifiers are used to bypass edits when they are set by NCCI as optional edits. The -59 modifier is both commonly used and commonly abused. According to the 2013 CERT Report data, a projected \$2.4 Billion in MPFS payments were made on lines with modifier -59, with a \$320 Million projected error rate. In facility payments, primarily OPFS, a projected \$11 Billion was billed on lines with a -59 modifier with a projected error of \$450 Million. This is a projected 1 year error of \$770 Million.

NOTE: that this is not entirely due to incorrect -59 modifier usage as other errors can and do exist on a -59 line. However, it has been observed that incorrect modifier usage was a major contributor although error code definitions do not allow an exact breakdown. If 10% of the errors on -59 lines are attributable to incorrect -59 modifier usage, that still amounts to a \$77 Million per year overpayment.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as a use to identify different encounters, different anatomic sites, and distinct services. Usage to identify a separate encounter is infrequent and usually correct; usage to define a separate anatomic site is less common and problematic; usage to define a distinct service is common and not infrequently overrides the edit in the exact circumstance for which CMS created the edit 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.

B. Policy:

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:

- 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
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier. CMS will not stop recognizing the -59 modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. CMS will continue to recognize the -59 modifier in many instances but 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, these modifiers are valid modifiers even before national edits are in place, so contractors 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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
8863.1	Shared System Maintainers and individual contractors shall accept and process claims containing lines reporting HCPCS codes with the new modifiers, XE, XP, XS and XU.	X	X			X				IOCE
8863.2	Shared System Maintainers and individual contractors shall apply or bypass edits to lines containing a - X{EPSU} modifier in the same manner as the edits would apply to a line containing a -59 modifier. Any edit that currently evaluates modifiers, such as a multiple procedure edit, should react to a - X{EPSU} in the same manner that it does to a -59.	X	X			X	X		X	IOCE
8863.3	Shared System Maintainers and individual contractors shall recognize each of the - X{EPSU} modifiers as a separate modifier. The system shall allow multiple lines to be reported with the -59 and different -	X	X			X	X			

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
	X{EPSU} modifiers. However, the system shall aggregate lines with any of the - X{EPSU} modifiers with lines containing -59 modifiers whenever it aggregates lines containing the -59 modifier.										
8863.4	Shared System Maintainers and individual contractors shall retain the - X{EPSU} modifiers in systems records and claims histories as valid and active modifiers.	X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	CEDI
		A	B	H H H		
8863.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1421	Date: August 15, 2014	Change Request: 8853
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SUBJECT: Revised Modification to the Medically Unlikely Edit (MUE) Program

EFFECTIVE DATE: January 1, 2015

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 5, 2015

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007 to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedural Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. Therefore, at that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. The following is the current and updated background information for this modification CR, including general processing instructions :

1. **MUEs for HCPCS codes with a MAI of “1”** will continue to be adjudicated as a claim line edit.
2. **MUEs for HCPCS codes with a MAI of “2”** will be absolute date of service edit. **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 UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability and Accountability Act (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than 1 unit of service for CPT 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of “2” denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy. Although the redetermination is a new look at the claim that is not dependent on the original determination, Medicare Administrative Contractors (MACs) are still bound by all levels of CMS policy. 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. The contractor may bypass the MUE for a HCPCS code with an MAI of “2” in response to effectuation instructions from a reconsideration or higher level appeal.

NOTE: Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and should therefore be aware that CMS considers all edits with an MAI of 2 to be firm limits based on sub-regulatory guidance, while some MUE edits with an MAI “2” may be based directly on regulation or statute.

Claims processing contractors will be required to sum all UOS for the code for the same date of service, for the same Health Insurance Claim Number (HICN), and for the same provider on:

- a. All claim lines of the current claim
- b. Paid claim lines of prior finalized claims

This number should be compared to the MUE value. If the sum of all UOS for the same date of service on all specified claims exceeds the MUE value for the code, contractors shall deny all claim lines for the code for the same date of service on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. All claim lines for HCPCS codes with an MAI of “2” on suspended claims shall be subjected to this claim adjudication process during final processing after release from suspended status. For MCS processed claims, the “same provider” is the rendering provider identified by NPI. For VMS processed claims, the “same provider” is based on the supplier number. For FISS processed claims, the “same provider” is the rendering provider.

3. MUEs for HCPCS codes with a MAI of “3” will be date of service edits. **These are “per day edits based on clinical benchmarks”**. If claim denials based on these edits are appealed, contractors may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If contractors 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 contractor 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.

Claims processing contractors will be required to sum all UOS for the code for the same date of service, for the same HICN, and for the same provider on:

- a. All claim lines of the current claim
- b. Paid claim lines of prior finalized claims

This number should be compared to the MUE value. If the sum of all UOS for the same date of service on all specified claims exceeds the MUE value for the code, claims processing contractors shall deny all claim lines for the code for the same date of service on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. Contractors may pay UOS in excess of the MUE value if there is pre-payment adequate documentation of medical necessity or on appeal of the denied claim(s). All claim lines for HCPCS codes with an MAI of “3” on suspended claims shall be subjected to this claim adjudication process during final processing after release from suspended status. For MCS processed claims, the same provider is the rendering provider identified by NPI. For VMS processed claims, the same provider is the based on the supplier number. For FISS processed claims, the same provider is the rendering provider.

4. General Processing Instructions.

Since ASC providers (specialty code 49) cannot report modifier 50, the MUE value used for editing should be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.

Contractors shall sum the units of service for multiple identical line items without any HCPCS/CPT modifier. Contractors shall deny all claim lines on current claims if the total UOS for multiple identical line items without any HCPCS/CPT modifier exceeds the MUE value for the HCPCS code.

However, for those situations in which the total UOS for multiple identical claim line items without any HCPCS/CPT modifier do not exceed the MUE value, current duplicate review policy remains in effect. That is, when potential duplicate line items are present on the same claim, contractors shall perform an automated or manual review of those line items to ensure they are processed (paid or denied) according to current system edit logic. Since MUEs are the last automated edits applied before CWF, the sequential position in the automated claims processing procedure of current duplicate review policy should not be altered.

Carriers/FIs/Part A/B MACs shall remind providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. Contractors may reopen or allow resubmission of those claims in accordance with their policies and with Pub 100-04, Claims Processing Manual, Chapter 34 Section 10.1, “Clerical errors (which includes minor errors and omissions) shall be treated as reopenings” Providers should be encouraged to change and resubmit their own claims where possible and to change their coding practices, but during reopening contractors 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. Those claims processing contractors shall also remind providers to 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.

B. Policy:

The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of seven columns. Contractors shall continue to use the Tabular Presentation Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the Fiscal Intermediary Shared System (FISS), and one for contractors using VIPS Medicare System (VMS) system. CMS has updated the table with a new column or data field which indicates the three levels of the MUE adjudication indicator (MAI).

Contractors shall apply MUEs to either claim lines or date of service, based on the MUE adjudication indicator (MAI) for that particular code, on or after the beginning effective date of an edit and before or on the ending effective date.

For HCPCS codes with a MAI of “1”, MUEs are set to auto-deny the claim line item if units of service on the claim line exceed the value in column 2 of the MUE table. For HCPCS codes with a MAI of “2” or “3”, all UOS for the same date of service on the current claim and prior finalized claims are summed, and if that sum exceeds the value in column 2 of the MUE table, all claim lines with that HCPCS code for that date of service are denied on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. Pub. 100-08, PIM, chapter 3, section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

When summing Units of Service, contractors shall apply MUEs to all lines with the same HCPCS code, regardless of modifiers (for the exception of modifier 55) or revenue codes. (Modifier 55 is exempt from MUE editing for all 3 MAI levels.) However, in applying MUEs to Critical Access Hospital claims (TOB 85X), contractors shall apply the Outpatient Hospital MUE once to UOS reported with any non-excluded revenue codes except 096X, 097X and 098X (i.e. Method 2 physician services), once to UOS reported with revenue codes 096X, 097X and 098X but without modifier AS, 80, 81 or 82 (i.e. primary surgeon), and once to UOS reported with revenue codes 096X, 097X and 098X and with modifier AS, 80, 81 or 82 (i.e. assistant surgeon). This applies the MUE separately to facility services, to physician/surgeon services and to assistant surgeon services.

For HCPCS codes with confidential MUEs (i.e., Publication Indicator = 0), the MAI levels may not be published or shared with anyone outside of your organization. All other MAIs for non-confidential MUEs can be published or shared.

The CMS will continue to set the units of service for each MUE 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, contractors are not expected to identify claims but should reopen impacted claims that are brought to their attention. Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to local contractors not the NCCI/MUE contractor, Correct Coding Solutions, LLC. Contractors adjudicating an appeal for a claim

denial for a HCPCS code with an MAI of “1” or “3” may pay medically necessary UOS in excess of the MUE value. As detailed in the Background, above, during processing, reopening, or redetermination claims processing contractors are not expected to pay UOS in excess of the MUE for a HCPCS code with an MAI of “2” because these edits are based on CMS sub-regulatory guidance. QICs and ALJs adjudicating an appeal for a claims denial for a HCPCS code with a MAI of “2,” are reminded that these edits are based in policy rather than clinical considerations so they may want to consider all evidence or documentation in that light prior to paying UOS in excess of the MUE value.

NOTE: Quarterly, the NCCI/MUE contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI/MUE contractor. The NCCI/MUE contractor may refer those concerns to CMS and the CMS MUE Workgroup, and CMS may change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an 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”, contractors should review the records to determine if the provider 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 is 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.” CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI 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.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly MUEs are distributed.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
8853.1	<p>CMS shared system maintainers shall update the data field language for the MUE adjudication indicators (MAIs), if needed, to allow CMS contractors (Carriers/FIs/Part A/B MACs/DME MACs) to adjudicate MUE claims appropriately based on MAI of 1, 2 or 3:</p> <p>MAI 1 - HCPCS codes with an MAI of 1 will continue to be adjudicated as a claim line edit.</p>					X					

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2636	Date: January 16, 2013
	Change Request 7501

Transmittal 2607, dated December 7, 2012 is rescinded and replaced by Transmittal 2636, dated January 16, 2013, to update the add-on code edit file to include a change in the list of primary codes for CPT code 90785. All other information remains the same.

SUBJECT: National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes - ACTION

I. SUMMARY OF CHANGES: An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code is never eligible for payment if it is the only procedure reported by a practitioner. This CR replaces an "Identical Letter" dated December 19, 1996 with subject line "Correct Coding Initiative Add-On (ZZZ) Codes - ACTION".

EFFECTIVE DATE: April 1, 2013

IMPLEMENTATION DATE: April 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):

The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:
Business Requirements**

**Unless otherwise specified, the effective date is the date of service.*

Attachment –Business Requirements

Pub. 100-04	Transmittal: 2636	Date: January 16, 2013	Change Request: 7501
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Transmittal 2607, dated December 7, 2012 is rescinded and replaced by Transmittal 2636, dated January 16, 2013, to update the add-on code edit file to include a change in the list of primary codes for CPT code 90785. All other information remains the same.

SUBJECT: National Correct Coding Initiative (NCCI) Add-On Codes – Replacement of "Identical Letter" Dated December 19, 1996 with Subject Line "Correct Coding Initiative Add-On (ZZZ) Codes - ACTION"

This CR will become a recurring change request that will be issued annually.

Effective Date: April 1, 2013

Implementation Date: April 1, 2013

I. GENERAL INFORMATION

A. Background:

An add-on code is a HCPCS/CPT code that describes a service that, with one exception (see next paragraph), is always performed in conjunction with another primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner.

The *Internet Only Manual, Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12(I) requires a provider to report CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) without its primary code CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) if two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service. For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292.

Add-on codes may be identified in three ways:

- (1) The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.
- (2) On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
- (3) In the *CPT Manual* an add-on code is designated by the symbol "+". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three Groups to distinguish the payment policy for each group.

(1) Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid. Pursuant to *Internet Only Manual, Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12(I) described in the "Background" section of this CR, CPT code 99292 may be paid to a physician who does not report CPT code 99291 if another physician of the same specialty in his group practice is paid for CPT code 99291 on the same date of service.

(2) Type II - A Type II add-on code does not have a specific list of primary procedure codes. The CR lists the Type II add-on codes without any primary procedure codes. Claims processing contractors are encouraged to develop their own lists of primary procedure codes for this type of add-on codes. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

(3) Type III - A Type III add-on code has some, but not all, specific primary procedure codes identified in the *CPT Manual*. The CR lists the Type III add-on codes with the primary procedure codes that are specifically identifiable. However, claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary procedure codes for add-on codes in this Type. Claims processing contractors are encouraged to develop their own lists of additional primary procedure codes for this group of add-on codes. Like the Type I add-on codes, a Type III add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

Rarely contractors may allow with appropriate submitted documentation, either pre-pay or on appeal, payment for a primary code and add-on code on two consecutive dates of service if the services are appropriately related.

CMS will update the list of add-on codes with their primary procedure codes on an annual basis before January 1 every year based on changes to the *CPT Manual*. Quarterly updates will be issued, as necessary, via a Change Request.

This CR replaces an "Identical Letter" dated December 19, 1996 with subject line "Correct Coding Initiative Add-On (ZZZ) Codes - ACTION".

B. Policy: Medicare Administrative Contractors (MACs) shall use add-on codes where appropriate. Use of add-on codes as part of NCCI is discussed in the Medicare Claims Processing Manual, Publication 100-04, Chapter 12 Physicians/Non-physician Practitioners, Section 30 Correct Coding Policy, Section D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A	D	F	C	R	Shared-System Maintainers	OTHER
		/	M	I	A	H		
		B	E		R	H		

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
7501.1	Medicare claims processing contractors shall use add on codes listed in attachment 1 as required below.	X			X						
7501.1.1	Medicare claims processing contractors shall adopt edits to assure that Type I add-on codes, except CPT code 99292, are paid only if a listed primary procedure code is also paid to the same practitioner for the same patient on the same date of service. Pursuant to <i>Internet Only Manual, Claims Processing Manual</i> , Publication 100-04, Chapter 12, Section 30.6.12(I) described in the “Background” section of this CR, CPT code 99292 may be paid to a physician who does not report CPT code 99291 if another physician of the same specialty in his group practice is paid for CPT code 99291 on the same date of service.	X			X						
7501.2	Medicare claims processing contractors shall rarely allow, with appropriate submitted documentation, either pre-pay or on appeal, payment for a primary code and add-on code on two consecutive dates of service if the services are appropriately related.	X			X						
7501.3	Medicare claims processing contractors shall implement and update the “Add On Code” edit list on an annual and quarterly basis, as necessary, with new add-on codes and modifications of primary procedure codes for existing add-on codes, within their claims processing systems.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A