



Medicare 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, Cloud Harbor Economics. The CMS website instructs providers to address concerns regarding specific CCI edits, including Medically Unlikely Edits, and Add-on edits in writing, via email to: NCCIPTPMUE@cms.hhs.gov.
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.

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). <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.

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.
 - 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.
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.

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. Listed below 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:
 - (i) < www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-correspondence-language-manual >

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.
 - 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. <See *One Time Notification 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 Fact Sheet*, 1783722 February 2024>
 - i. Treatment of contiguous structures of the same organ do not constitute different anatomic sites. See *MLN Fact Sheet*, 1783722 February 2024>
 - b. During different patient encounters. < See *MLN Fact Sheet*, 1783722, February 2024>
 - (b) Additional examples and guidance may be found under the CMS Medicare National Correct Coding Initiative (NCCI) Edits page on the CMS website, under the link "Proper Use of Modifiers 59, XE, XP, XS, & XU".
 - (c) CMS has defined four HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows: <See *MLN Fact Sheet*, 1783722, February 2024>

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.

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 Policy 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.
 - 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>

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. <See 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. < See 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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MEDICARE NATIONAL CORRECT CODING INITIATIVE**CORRESPONDENCE LANGUAGE MANUAL**

Effective February 28, 2024


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Introduction

As the largest payer for health care services, CMS-administered programs are a target for improper payments and schemes to defraud federal health care programs of billions of dollars annually.¹ Accurate coding and reporting of services by providers and suppliers is a critical aspect of assuring proper payments. To address this requirement, CMS developed and implemented NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in the Medicare Part B program. The NCCI program has since been expanded to include Medicaid under section 6507 of the Patient Protection and Affordable Care Act.

The NCCI program includes 3 types of edits: Procedure-to Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code (AOC) Edits.

- **PTP edits** - prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the 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.
- **MUE edits** - prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.
- **AOC edits** - consist of a listing of HCPCS and CPT Add-on Codes with their respective primary codes. An Add-on Code is eligible for payment if and only if one of its primary codes is also eligible for payment.

Claims are denied by NCCI edits based on a determination of inappropriate coding, not on the basis of medical necessity. Correct coding is a separate activity from medical review in that no further clinical judgment is needed to deny a claim; therefore, the denial can be automated. Certain edits also include indicators that certain edits may or may not be bypassed with a modifier.

More detailed information about the Medicare and Medicaid NCCI Programs is available on the [National Correct Coding Initiative \(NCCI\) home page](#).

Each NCCI PTP edit and MUE has a corresponding Correspondence Language Example Identification Number (CLEID). CLEID tables are only available to Medicare claims processing contractors and provide information about the rationale for these edits that can be used to help educate providers about the edits. For example, a Medicare contractor may refer to the CLEID when responding to an inquiry about a specific NCCI PTP edit or MUE or to an appeal of a claim line that was denied due to an edit. NCCI PTP edit files posted on the [Medicare NCCI Procedure to Procedure \(PTP\) Edits webpage](#) do not include CLEIDs. The following information provides guidance to providers when a Medicare contractor references a CLEID.

¹ See the Department of Health and Human Services Agency Financial Report, <https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf>

The CLEID is formatted as DD.EEEEEEEEEE.

DD identifies the general policy that provides the rationale for the edit. There are fourteen categories of general policies for NCCI PTP edits.

1. Standard preparation/monitoring services for anesthesia
2. HCPCS/CPT procedure code definition
3. CPT Manual or CMS manual coding instruction
4. Mutually exclusive procedures
5. Sequential procedure
6. CPT Separate procedure definition
7. More extensive procedure
8. Reserved for future use
9. Gender-specific procedures
10. Standards of medical/surgical practice
11. Anesthesia service included in surgical procedure
12. Laboratory panel
13. Deleted/modified edits for the NCCI program
14. Misuse of Column Two code with Column One code

There are 2 categories of general policies for MUEs.

15. MUEs based on units of service (UOS)
16. Deleted/modified edits for MUE(s)

Detailed information about each of the general policies can be found in individual sections of Chapter I of the NCCI Policy Manual for Medicare Services which is posted on the [Medicare NCCI Policy Manual webpage](#). The general correspondence language relating to each of these policy categories is found in this Manual.

EEEEEEEEE identifies the section of this Manual to use for a specific example related to the policy statement. For example, if EEEEEEEEE is 10000, the example refers to Column One CPT codes from the 10000 series of codes in the CPT Manual. For NCCI PTP edits with a Column One HCPCS code of A0000 – V9999, the entry for EEEEEEEEE is A – V rather than a number.

When developing correspondence using the Correspondence Language Manual, Medicare claims processing contractors use two paragraphs from this Manual.

- The first paragraph is the relevant General Correspondence Language statement as identified by DD. For NCCI PTP edits, the Column One and Column Two codes of the edit pair in question are entered in appropriate spaces in that paragraph.
- The second paragraph is the relevant section-specific example as identified by EEEEEEEEE.

For example, for the NCCI PTP edit with a Column One code of 37760 and a Column Two code of 15271, the CLEID is 2.30000. An individual providing an explanation of this edit would use two paragraphs from the Correspondence Language Manual. The first paragraph would be the paragraph 2 HCPCS/CPT procedure code definition from the General Correspondence Language portion of this Manual. The second paragraph would be selected from the Section Specific Examples for the 30000 series of codes, “Respiratory, Cardiovascular, Hemic and Lymphatic Systems”. The correspondent would select the example identified as CLEID 2.30000. The two paragraphs would be:

- “The HCPCS/CPT procedure code definition, or descriptor, is based upon contemporary medical practice. When a HCPCS/CPT code is submitted to Medicare, all services described by the descriptor should have been performed. Because some HCPCS/CPT codes describe complex procedures with several components which may under certain circumstances be performed independently, some of the component procedures have their own HCPCS/CPT codes. If a HCPCS/CPT code is reported along with other HCPCS/CPT codes that are components of the descriptor of the first code, only the first code should be reported. The HCPCS/CPT code 37760 descriptor includes the service described by the descriptor of HCPCS/CPT code 15271. Thus, based upon the HCPCS/CPT code descriptors, HCPCS/CPT code 15271 is bundled into HCPCS/CPT code 37760.”
- “For example, the code descriptor for CPT code 33612 is “Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction” and the code descriptor for CPT code 33611 is “Repair of double outlet right ventricle with intraventricular tunnel repair.” Therefore, based upon the code descriptors the procedure described by CPT code 33611 is a component of the procedure described by CPT code 33612, and CPT code 33611 is bundled into CPT code 33612.”



National Correct Coding Initiative General Correspondence Language Policies

1. Standard preparation/monitoring services for anesthesia: Anesthesia services require certain services to prepare a patient before the administration of anesthesia and to monitor a patient during the course of anesthesia. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if needed. The specific services necessary to prepare and monitor a patient vary among procedures based upon the extent of the surgical procedure, the type of anesthesia (general, monitored anesthesia care, regional, local, etc.), and the surgical risk. The physician determines which preparation and monitoring services are used for an anesthesia procedure. These services are included in the anesthesia service. Accordingly, when reporting the anesthesia service code, HCPCS/CPT code _____ (the Column One HCPCS/CPT code), the services described by HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) are included in the anesthesia service.
2. HCPCS/CPT procedure code definition: The HCPCS/CPT procedure code definition, or descriptor, is based upon contemporary medical practice. When a HCPCS/CPT code is submitted to Medicare, all services described by the descriptor should have been

performed. Because some HCPCS/CPT codes describe complex procedures with several components which may under certain circumstances be performed independently, some of the component procedures have their own HCPCS/CPT codes. If a HCPCS/CPT code is reported along with other HCPCS/CPT codes that are components of the descriptor of the first code, only the first code should be reported. The HCPCS/CPT code _____ (the Column One HCPCS/CPT code) descriptor includes the service described by the descriptor of HCPCS/CPT code _____ (the Column Two HCPCS/CPT code). Thus, based upon the HCPCS/CPT code descriptors, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is bundled into HCPCS/CPT code _____ (the Column One HCPCS/CPT code).

3. CPT Manual or CMS manual coding instruction: In addition to CPT procedure code definitions or descriptors, instructions in the CPT Manual are provided either as an introduction to CPT sections or parenthetically. Additionally, CMS issues coding instructions and guidelines in its manuals, program memoranda, and other publications. In the case of HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code), CPT or CMS instructions identify appropriate methodology for code submission and accordingly, HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) is included in or cannot be reported with HCPCS/CPT code _____ (the Column One HCPCS/CPT code).
4. Mutually exclusive procedures: To provide a sufficiently broad listing of descriptive terms and identifying HCPCS/CPT codes, certain services or procedures are listed which would not reasonably be performed at the same session by the same provider on the same beneficiary. In the case of HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code), it would be unreasonable to expect these services to be performed at a single patient encounter, therefore, these HCPCS/CPT codes have been paired together as edits.
5. Sequential procedure: If a provider attempts several procedures in direct succession at a patient encounter to accomplish the same end, only the procedure that successfully accomplishes the expected result is reported. Generally, this occurs when a less extensive procedure fails and requires the performance of a more extensive procedure. A failed procedure followed by a more extensive procedure should not be reported separately. Procedures that are often performed in sequence have been identified and the less extensive procedure is not separately reportable with the more extensive procedure. When the procedures corresponding to HCPCS/CPT code _____ (the Column One HCPCS/CPT code) and HCPCS/CPT code _____ (the Column Two HCPCS/CPT code) are performed in sequence at the same patient encounter, only HCPCS/CPT code _____ (the Column One HCPCS/CPT code) may be reported.
6. CPT "Separate procedure" definition: The narrative for many HCPCS/CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. A "separate procedure"

should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or surgical approach.

HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is designated as a "separate procedure." Therefore, if it is reported with HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code), HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is bundled into HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code).

7. More extensive procedure: Some procedures can be performed at varying levels of complexity. The HCPSCS/CPT codes corresponding to more extensive procedures always include the HCPSCS/CPT codes corresponding to less complex procedures. HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code) is a more extensive procedure that includes HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code). Accordingly, only the more extensive procedure, HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code) should be reported. HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is bundled into HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code).
8. Reserved for Future Use
9. Gender-specific procedures: The performance of certain procedures may require significantly different approaches when performed in a male as opposed to a female. Some HCPSCS/CPT code descriptors designate these procedures by specifying if the service or procedure is to be reported for a male or a female or by anatomical description. HCPSCS/CPT code combinations that describe identical procedures, except that one code describes a procedure for a female and the other describes a procedure for a male, cannot be reported for the same beneficiary by the same provider at the same session. HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code) and HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) represent such a combination and should not be reported together.
10. Standards of medical/surgical practice: Under Medicare, all services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. Many procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent HCPSCS/CPT codes because they may be performed independently in other settings. The service described by HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is typically included when performing the procedure described by HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code) and is therefore bundled into HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code).
11. Anesthesia service included in surgical procedure: Pursuant to Medicare's Anesthesiology Rules, Medicare does not pay separately for anesthesia other than moderate conscious sedation under certain circumstances when provided by the same physician who performs the medical or surgical procedure requiring the anesthesia.

HCPSCS/CPT codes describing anesthesia services or services that are bundled into anesthesia services should not be reported in addition to the surgical procedure requiring the anesthesia services. Accordingly, HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code representing the anesthesia service or service bundled into anesthesia) is included in the surgical service described by HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code).

12. Laboratory panel: Laboratory panels, described in CPT as "Organ or Disease Oriented Panels," define groupings of laboratory tests that are commonly performed together in clinical practice. When a HCPSCS/CPT code describing a panel is reported, HCPSCS/CPT codes identifying the individual tests included in the panel should not be reported separately. HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code representing the laboratory panel) includes HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code). Therefore, HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is bundled into HCPSCS/CPT code _____ (the laboratory panel code or the Column One HCPSCS/CPT code).
13. Deleted/modified edits for NCCI: NCCI edits were developed based upon review of existing local and national edits, review of standards of medical care, review of CPT instructions and descriptors, review of provider billing patterns and Medicare policies. Comments about NCCI PTP edits are received from the AMA and the national medical societies, representatives of the AMA's CPT Editorial Panel, CPT Advisory, and Health Care Professionals Advisory (HCPAC) Committees, Contractor Medical Directors, contractor staff, physicians, other providers, and independent billing consultants. Based upon input from these sources, NCCI PTP edits are sometimes deleted. NCCI PTP edits may also be deleted for other reasons such as CMS policies, modified HCPSCS/CPT code descriptors or coding instructions, deletion of HCPSCS/CPT codes, or modified medical practice. (Occasionally the order of the codes in an edit needs to be reversed. In such situations, the original edit is deleted, and a new edit is added with the order of the codes reversed.) The HCPSCS/CPT code pair edit, HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code) and HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) was deleted from the NCCI program for one of these reasons.
14. Misuse of Column Two code with Column One code: HCPSCS/CPT codes have been written as precisely as possible to not only describe a specific procedure but to also avoid describing similar procedures which are already defined by other HCPSCS/CPT codes. When a HCPSCS/CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Occasionally, a HCPSCS/CPT code descriptor will identify certain services that may or may not be included.) A HCPSCS/CPT code should not be reported out of the context for which it was intended. When the procedure described by HCPSCS/CPT code _____ (the Column Two HCPSCS/CPT code) is reported with the procedure described by HCPSCS/CPT code _____ (the Column One HCPSCS/CPT code), reporting the former code represents a misuse of this code, and separate payment is not allowed.

15. Medically Unlikely Edits (UOS): Most HCPCS/CPT codes describe procedures that may be reported a maximum number of times by a single provider for the same beneficiary on the same date of service. If a provider bills UOS for HCPCS/CPT codes in excess of established limits, the edits prevent payment. The MUE values are set based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT coding instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment based on input from many sources. MUE values were reviewed by national healthcare organizations before implementation. Most established MUE values have been evaluated with 100% claims data from a 6-month period. CMS publishes most MUE values. However, unpublished MUE values are confidential information for CMS and CMS's contractors' use only. No information about unpublished MUE values shall be released or shared outside your organization.
16. Deleted/modified edits for MUE: MUEs were developed based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT coding instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and/or clinical judgment. Before implementation, most MUEs were reviewed by national healthcare organizations. Comments about MUEs are received from the AMA and the national healthcare organizations (NHOs), representatives of the AMA's CPT Editorial Panel, CPT Advisory, and Health Care Professionals Advisory (HCPAC) Committees, Medicare Contractor Medical Directors, contractor staff, physicians, other providers, and independent billing consultants. Based upon input from these sources, an MUE may be deleted. MUEs may also be deleted for other reasons such as CMS policies, modified HCPCS/CPT code descriptors or coding instructions, deletion of HCPCS/CPT codes, or modified medical practice. (Occasionally an MUE is modified. In such situations the original MUE is deleted, and a new MUE with the revised MUE value is added). The MUE for the HCPCS/CPT code _____ was deleted or modified for one of these reasons.

National Correct Coding Initiative Medicare Correspondence Language Section-Specific Examples

Anesthesia Services CPT Codes 00000-09999

CLEID 1.00000 - Standard preparation/monitoring services for anesthesia

An example of a "standard preparation/monitoring service" integral to anesthesia services is the placement of an intravenous access line (CPT code 36000) before the administration of general anesthesia. This procedure is necessary to prepare the patient for a general anesthesia procedure and, therefore, is included as a part of the anesthesia service. CPT code 36000 is bundled into all anesthesia service codes.

CLEID 3.00000 - CPT Manual or CMS manual coding instruction

For example, in the CPT Manual instruction under anesthesia for diagnostic arteriography/venography (CPT code 01916), the reference note states: "Do not report 01916 in conjunction with therapeutic codes 01924-01926, 01930-01933." Therefore, CPT code 01916 is

Medicare Claims Processing Manual, Chapter 23

Excerpt

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

Field	Type	Record Position	Length
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

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

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**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) jurisdictions. Accurate coding and reporting of services are critical aspects 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) Professional*, 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 Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (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 allowed and 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) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims 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, outpatient therapy services, and others listed in the [How to Use NCCI Tools booklet](#). They are not applied to facility claims for inpatient services.



NCCI Program Background

Although the NCCI program was initially developed for use by Medicare Carriers (A/B MACs) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by MACs to process claims for Part B outpatient hospital services. 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 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.

On January 1, 2007, the CMS incorporated MUEs into the NCCI program. These edits are applicable to claims submitted to A/B MACs, Durable Medical Equipment (DME) MACs.

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.

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 practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes

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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.

CMS implements NCCI PTP edits after due consideration of Medicare policies including the principles described in the *Medicare NCCI Policy Manual*, HCPCS and *CPT Professional* code descriptors, *CPT Professional* 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 Professional* 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

CMS developed the *Medicare NCCI Policy Manual*, NCCI PTP edits, MUEs, and AOC edits for application to Medicare services billed by a single provider/supplier for a single patient on the

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same date of service.

CMS developed the *Medicare NCCI Policy Manual* 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 *Medicare NCCI Policy Manual* and edits were initially based on evaluation of procedures referenced in the 1994 *CPT Professional* 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 *Medicare NCCI Policy Manual* includes an Introduction, and 13 narrative chapters. Each chapter corresponds to a separate section of the *CPT Professional* 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 *Medicare NCCI Policy Manual*, in general, uses paraphrased descriptors of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's *CPT Professional* 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. 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 Professional* 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 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

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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. 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.

CMS implements edit revisions **as soon as technically possible, and they** 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, 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-deny 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
 - h. **Helpful Educational Materials e.g.,** How to Use Medicare NCCI Tools
2. NCCI for Medicaid
 - a. Edit Files
 - b. MUE Archive
 - c. Methodologies

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- d. Reference Documents
 - i. *Medicaid NCCI Policy Manual* (Current Version and Archived Manuals)
 - ii. Correspondence Language Manual
 - iii. Technical Guidance Manual
- e. FAQ Library
- f. **Helpful Educational Materials e.g.** How to Use the Medicaid NCCI Tools



Correspondence **with** CMS about the **Medicare** NCCI Program and its Contents

The NCCI program cannot answer questions outside of our scope, or questions about other CMS programs or about other payors. For example, we cannot answer questions about Local Coverage Determinations, changes to code descriptors or status indicators, or modifiers not associated with NCCI.

The NCCI webpages include edit files, FAQs, and additional information. CMS does not provide a look-up service or a clean claims tool.

A provider, health care organization, or other interested party may request reconsideration of an NCCI PTP edit, an AOC edit, or an MUE value. A written request should include the rationale for the proposed change. For a PTP edit, specify the Column One and Column Two code pair(s). For an AOC edit, specify the AOC and the primary code(s). For an MUE, suggest an alternative MUE value. All written requests should specify the NCCI program (i.e., Medicare or Medicaid) and the edit type (i.e., Practitioner/Ambulatory Surgical Center, Outpatient Hospital Facility, or Durable Medical Equipment).

****NOTE**** Don't submit any Personally Identifiable Information (PII) or Protected Health Information (PHI).

The NCCI program may address general questions and concerns about the NCCI program and edits. You must submit claim-specific inquiries to the MAC. This includes appeals of NCCI-related denials; see Submitting an Appeal below.

The NCCI contractor maintains the **Medicare** NCCI program for CMS. If **you have comments about** the edits or this manual, **you** may send an inquiry in writing to NCCIPTPMUE@cms.hhs.gov.

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



Submitting an Appeal

You must submit appeals to your responsible MAC or QIC, not the NCCI Contractor. To file an appeal, please follow the instructions on the [Appeals website](#). The NCCI contractor cannot process specific claim appeals and cannot forward appeal submissions to the appropriate appeals contractor.

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Other Payors

The NCCI program provides general information to the public regarding the NCCI program and edits. However, we do not provide specific billing or coding advice to providers/suppliers. Questions regarding specific claims (e.g., specific scenarios) should be addressed to your payor.

If the issue you are having applies to other government, third-party, or private insurers who voluntarily choose to implement NCCI edits, we do not have control over how those edits are applied outside of Medicare. If you have questions about other plans, please contact your payer. If you have questions or concerns regarding specific Medicare claims, please contact your local Medicare Administrative Contractor (MAC).

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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

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

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

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

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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Proper Use of Modifiers 59, XE, XP, XS, & XU

What's Changed

Added information on the use of modifier 59 in RHC and FQHC settings (page 5)

Substantive content changes are in dark red.

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 in all or most situations. These edits allow the following:

- For NCCI PTP edits with a Correct Coding Modifier Indicator (CCMI) of "0," don't report the codes together by the same provider for the same patient on the same date of service (DOS). If you do report the codes together on the same DOS, the Column 1 code is eligible for payment and Medicare denies the Column 2 code.
- For NCCI PTP edits that have a CCMI of "1," report the codes together only in limited circumstances by using NCCI PTP-associated modifiers.

Refer to Chapter 1 of the [Medicare NCCI Policy Manual](#) for general information about the NCCI program, NCCI PTP edits, CCMI, and NCCI PTP-associated modifiers. One purpose of NCCI PTP 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 physicians and providers often use incorrectly. This fact sheet will help you use this modifier correctly.

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

The CPT Manual defines modifier 59 as:

"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, XE, XS, XP, XU, 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 support the use of the modifier.

Modifiers 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, XE, XS, XP, XU on Column 1 or Column 2 codes (see the related transmittal at [CR 11168](#) and [MM11168](#)).

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 DOS.
- 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
- Different anatomic regions
- 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.
- Can't be described by 1 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. 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 performed during different patient encounters on the same day that can't be described by 1 of the more specific NCCI PTP-associated modifiers – in other words, 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 DOS, you may use modifiers 59, XE, or XS to show that they're different procedures on that DOS. Also, there may be limited circumstances sometimes identified in the Medicare [NCCI Policy Manual](#) when you may report the 2 codes of an edit pair together with modifiers 59, XE, or XS when performed at the same patient encounter or at the same anatomic site.

4. Other specific proper uses of modifiers 59, XE, or XU

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're 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 (2 examples are: per 15 minutes or per hour). If you provide 2 timed services in separate and distinct time periods and aren't mingled with each other (in other words, you complete 1 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 you perform a diagnostic procedure before a surgical procedure or non-surgical therapeutic procedure and it's the basis on which you decide to perform the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure if it:
- Occurs before the therapeutic procedure and isn't mingled with services the therapeutic intervention requires.
 - Clearly provides the information needed to decide whether to proceed with the therapeutic procedure.
 - Doesn't constitute a service that would've 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 if it:
- Occurs after the completion of the therapeutic procedure and isn't mingled with or otherwise mixed with services that the therapeutic intervention requires.
 - Doesn't constitute a service that would've 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, XE, XS, XP, XU doesn'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, XE, XS, XP, XU. The HCPCS or CPT codes remain bundled unless you perform the procedures at different anatomic sites or separate patient encounters or meet 1 of the other 3 scenarios described by A, B, or C above.

Rural Health Clinics & Federally Qualified Health Centers

A single Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) visit constitutes more than 1 RHC or FQHC practitioner encounter on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day. It's payable as 1 visit. This policy applies regardless of all of these:

- Length or complexity of the visit
- Number or type of practitioners seen
- Second visit is scheduled or unscheduled
- First visit is related or unrelated to the subsequent visit

An exception to this policy occurs when the patient, after the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to show that the treatment qualifies for 2 billable visits.

The only other exceptions are:

- The patient has a medical visit and a mental health visit on the same day (2 billable visits)
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical, mental health visit, or both on the same day as the IPPE (2 or 3 billable visits)

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, XE, XS, XP, XU if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure 47370. Only report 76942 with modifiers 59, XE, XS, XP, XU 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, XE, XS, XP, XU for fluoroscopy in conjunction with a cardiac catheterization procedure. You may report 76000 with modifiers 59, XE, XS, XP, XU 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, XE, XS, XP, XU 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, XE, XS, XP, XU 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, XE, XS, XP, XU 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, XE, XS, XP, XU.

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, XE, XS, XP, XU 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, XE, XS, XP, XU 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 97750 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.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

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](#)
- Section 40.3 of the [Medicare Benefit Policy Manual, Chapter 13](#)

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

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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

V. CONTACTS

Pre-Implementation Contact(s): Valeria Allen, 410-786-7443 or valeria.allen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: 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 obligated 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.

ATTACHMENTS: 0

Version 04/25/2024
Check for Updates

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2259	Date: February 15, 2019
	Change Request 11168

SUBJECT: 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

I. SUMMARY OF CHANGES: National Correct Coding Initiative (NCCI) procedure to procedure (PTP) edits consist of column one and column two codes. If a PTP edit has a CCMI (modifier indicator) of "1", the PTP edit shall be bypassed if submitted with an NCCI-associated modifier.

EFFECTIVE DATE: July 1, 2019

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

IMPLEMENTATION DATE: July 1, 2019

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 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 obligated 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: 2259	Date: February 15, 2019	Change Request: 11168
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SUBJECT: 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

EFFECTIVE DATE: July 1, 2019

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

IMPLEMENTATION DATE: July 1, 2019

I. GENERAL INFORMATION

A. Background: Modifiers 59, XE, XS, XP, and XU are included among the NCCI-associated modifiers. MCS currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit in order to bypass the edit.

B. Policy: CMS now allows the modifier 59, XE, XS, XP, or XU on column one and two codes. This change will be effective on or after July 1, 2019.

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		F	M	V	C			
				H H H	M I S S	C S S	M S S	W F			
11168.1	MCS system maintainers shall update the claim adjudication rules for NCCI PTP edits to allow bypass of an edit with CCM1 of "1" if modifiers 59, XE, XS, XP, or XU are appended to either the column one or column two code.		X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC			D M E						C E D I
		A	B	H H H							
11168.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter		X								

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Cecily Spaulding, cecily.spaulding@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 obligated 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.

ATTACHMENTS: 0

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

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Valeria Allen at 410-786-7743 or Valeria.Allen@cms.hhs.gov

Post-Implementation Contact(s):

Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: 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 obligated 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.

NOTE: Use of add on codes as part of CCI 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.

This CR makes no change to the chapter.

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
01953	01952
01968	01967
01969	01967
11001	11000
11008	10180, 11004-11006
11045	11042
11046	11043
11047	11044
11101	11100
11201	11200
11732	11730
11922	11921
13102	13101
13122	13121
13133	13132
13153	13152
14302	14301
15003	15002
15005	15004
15101	15100
15111	15110
15116	15115
15121	15120
15131	15130
15136	15135
15151	15150
15152	15151
15156	15155
15157	15156
15201	15200
15221	15220
15241	15240
15261	15260
15272	15271
15274	15273
15276	15275
15278	15277
15787	15786
15847	15830
16036	16035
17003	17000
17312	17311
17314	17313
17315	17311-17314
19001	19000
19126	19125
19291	19290
19295	10022, 19102, 19103
19297	19301, 19302
20930	22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812
20931	22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
20936	22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812
20937	22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812
20938	22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812
22103	22100, 22101, 22102
22116	22110, 22112, 22114
22208	22206, 22207
22216	22210, 22212, 22214
22226	22220, 22222, 22224
22328	22325-22327
22522	22520, 22521
22525	22523, 22524
22527	22526
22534	22532, 22533
22552	22551
22585	22554, 22556, 22558
22614	22600, 22610, 22612, 22630 or 22633 when performed at a different level
22632	22612, 22630 or 22633 when performed at a different level
22634	22633
22840	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22841	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22842	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22843	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22844	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22845	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
22846	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22847	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22848	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
22851	22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307
26125	26123
26861	26860
26863	26862
27358	27355, 27356, 27357
27692	27690, 27691
29826	29806-29825, 29827, 29828
31620	31622-31646
31627	31615, 31622-31626, 31628-31631, 31635, 31636, 31638-31643
31632	31628
31633	31629
31637	31636
31649	31648
31651	31647
32501	32480, 32482, 32484
32506	32505
32507	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504
32667	32666
32668	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671
32674	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32663, 32666, 32667, 32669, 32670, 32671
33141	33400-33496, 33510-33536, 33542
33225	33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33222, 33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, 33264
33257	33120-33130, 33250-33251, 33261, 33300-33335, 33400-33496, 33500-33507, 33510-33516, 33533-33548, 33600-33619, 33641-33697, 33702-33732, 33735-33767, 33770-33814, 33840-33877, 33910-33922, 33925-33926, 33935, 33945, 33975-33980
33258	33130, 33250, 33300, 33310, 33320, 33321, 33330, 33332, 33401, 33414-33417, 33420, 33470-33472, 33501-33503, 33510-33516, 33533-33536, 33690, 33735, 33737, 33800-33813, 33840-33852, 33915, 33925
33259	33120, 33251, 33261, 33305, 33315, 33322, 33335, 33400, 33403-33413, 33422-33468, 33474-33478, 33496, 33500, 33504-33507, 33510-33516, 33533-33548, 33600-33688, 33692-33722, 33730, 33732, 33736, 33750-33767, 33770-33781, 33786-33788, 33814, 33853, 33860-33877, 33910, 33916-33922, 33926, 33935, 33945, 33975-33980
33367	33361-33365, 0318T
33368	33361-33365, 0318T

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
33369	33361-33365, 0318T
33508	33510-33523
33517	33533-33536
33518	33533-33536
33519	33533-33536
33521	33533-33536
33522	33533-33536
33523	33533-33536
33530	33400-33496, 33510-33536, 33863
33572	33510-33516, 33533-33536
33768	33478, 33617, 33622, 33767
33884	33883
33924	33470-33475, 33600-33619, 33684-33688, 33692-33697, 33735-33767, 33770-33781, 33786, 33920-33922
34806	33880, 33881, 33886, 34800-34805, 34825, 34900
34808	34800, 34805, 34813, 34825, 34826
34813	34812
34826	34825
35306	35305
35390	35301
35500	33510-33536, 35556, 35566, 35570, 35571, 35583-35587
35572	33510-33516, 33517-33523, 33533-33536, 34502, 34520, 35001, 35002, 35011-35022, 35102, 35103, 35121-35152, 35231-35256, 35501-35587, 35879-35907
35600	33533-33536
35682	35556, 35566, 35570, 35571, 35583-35587
35683	35556, 35566, 35570, 35571, 35583-35587
35685	35656, 35666, 35671
35686	35556, 35566, 35570, 35571, 35583-35587, 35623, 35656, 35666, 35671
35700	35556, 35566, 35570, 35571, 35583, 35585, 35587, 35656, 35666, 35671
36148	36147
36218	36216, 36217
36227	36222, 36223, 36224
36228	36224, 36226
36248	36246, 36247
36476	36475
36479	36478
37185	37184
37206	37205
37208	37207
37222	37220, 37221
37223	37221
37232	37228-37231
37233	37229, 37231
37234	37229, 37230, 37231
37235	37231
37251	37250
38746	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505
38900	19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745
43273	43260-43265, 43267-43272
43283	43280, 43281, 43282
43338	43280, 43327-43337
43635	43631, 43632, 43633, 43634
44121	44120
44128	44126, 44127
44139	44140-44147
44203	44202

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
44213	44204-44208
44701	44140, 44145, 44150, 44604
49326	49324, 49325
49435	49324, 49421
49568	11004-11006, 49560-49566
51797	51728, 51729
56606	56605
57267	45560, 57240-57265, 57285
58110	57420, 57421, 57452-57461
59525	59510, 59514, 59515, 59618, 59620, 59622
60512	60500, 60502, 60505, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271
61316	61304, 61312, 61313, 61322, 61323, 61340, 61570, 61571, 61680-61705
61517	61510, 61518
61609	61605-61608
61610	61605-61608
61611	61605-61608
61612	61605-61608
61641	61640
61642	61640
61797	61796, 61798
61799	61798
61800	61796, 61798
61864	61863
61868	61867
62148	62140-62147
62160	61107, 61210, 62220-62230, 62258
63035	63020-63030
63043	63040
63044	63042
63048	63045-63047
63057	63055, 63056
63066	63064
63076	63075
63078	63077
63082	63081
63086	63085
63088	63087
63091	63090
63103	63101, 63102
63295	63172, 63173, 63185, 63190, 63200-63290
63308	63300-63307
63621	63620
64480	64479
64484	64483
64491	64490
64492	64490
64494	64493
64495	64493
64634	64633
64636	64635
64778	64776
64783	64782
64787	64774-64786
64832	64831
64837	64834-64836
64859	64856, 64857

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
64872	64831-64865
64874	64831-64865
64876	64831-64865
64901	64885-64893
64902	64885, 64886, 64895-64898
65757	65756
66990	65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, 67112, 67113
67225	67221
67320	67311-67318
67331	67311-67318
67332	67311-67318
67334	67311-67318
67335	67311-67334
67340	67311-67334
69990	61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64891, 64905-64907 based on <i>Internet Only Manual, Medicare Claims Processing Manual</i> , Publication 100-04, Chapter 12, Section 20.4.5 (Allowable Adjustments)
74301	74300
75565	75557, 75559, 75561, 75563
75946	75945
75964	75962
75968	75966
76802	76801
76810	76805
76812	76811
76814	76813
77051	77055, 77056, G0204, G0206
77052	77057, G0202
78020	78018
78496	78472
78730	78740
81266	81265
82952	82951
86826	86825
87187	87186, 87188
87503	87502
87904	87903
88155	88142-88154, 88164-88167, 88174-88175
88177	88172
88185	88184
88314	17311-17315, 88302-88309, 88331, 88332
88332	88331
88334	88331, 88333
88388	88329-88334
90461	90460
90472	90460, 90471, 90473, G0008, G0009, G0010
90474	90460, 90471, 90473, G0008, G0009, G0010
90785	90791, 90792, 90832, 90834, 90837, 90833, 90836, 90838, 90853
90833	99201-99255, 99304-99337, 99341-99350
90836	99201-99255, 99304-99337, 99341-99350
90838	99201-99255, 99304-99337, 99341-99350
90840	90839
90863	90832, 90834, 90837
91013	91010

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
92547	92540-92546
92608	92607
92618	92605
92621	92620
92627	92626
92921	92920, 92924, 92928, 92933, 92937, 92941, 92943
92925	92924, 92928, 92933, 92937, 92941, 92943
92929	92928, 92933, 92937, 92941, 92943
92934	92933, 92937, 92941, 92943
92938	92937
92944	92924, 92928, 92933, 92937, 92941, 92943
92973	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564
92974	92920, 92924, 92928, 92933, 92937, 92941, 92943, 93454-93461
92978	92975, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 93454-93461, 93563, 93564
92979	92978
92998	92997
93320	93303, 93304, 93312, 93314, 93315, 93317, 93350, 93351, C8921, C8922, C8925, C8926, C8928, C8930
93321	93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, 93351, C8921, C8922, C8924, C8925, C8926, C8928, C8930
93325	76825, 76826, 76827, 76828, 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, 93351, C8921, C8922, C8924, C8925, C8926, C8928, C8930
93352	93350, 93351
93462	93452, 93453, 93458-93461, 93653, 93654
93463	93451-93453, 93456-93461, 93563, 93564, 93580, 93581
93464	93451-93453, 93456-93461, 93530-93533
93563	93530-93533
93564	93530-93533
93565	93530-93533
93566	93451, 93453, 93456, 93457, 93460, 93461, 93530-93533
93567	93451-93461, 93530-93533
93568	93451, 93453, 93456, 93457, 93460, 93461, 93530-93533
93571	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564
93572	93571
93609	93620, 93653
93613	93620, 93653
93621	93620
93622	93620
93623	93619, 93620
93655	93653, 93654, 93656
93657	93656
93662	92987, 93453, 93460-93462, 93532, 93580, 93581, 93621, 93622, 93653, 93654, 93656
94645	94644
94729	94010, 94060, 94070, 94375, 94726-94728
94781	94780
95079	95076
95873	64612-64614
95874	64612-64614
95885	95907-95913
95886	95907-95913
95887	95907-95913
95940	92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939
95941	92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939

**TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES
(BASED ON 2013 CPT MANUAL)**

ADD-ON CODE	PRIMARY CODE(S)
95962	95961
95967	95966
95973	95972
95975	95974
95979	95978
96361	96360
96366	96365, 96367
96367	96365, 96374, 96409, 96413
96368	96365, 96366, 96413, 96415, 96416, C8957
96370	96369
96371	96369
96375	96365, 96374, 96409, 96413
96376 - may be reported by facilities only	96365, 96374, 96409, 96413
96411	96409, 96413
96415	96413
96417	96413
96423	96422
96570	31641, 43228
96571	31641, 43228
97546	97545
97598	97597
97811	97810, 97813
97814	97810, 97813
99145	99143, 99144
99150	99148, 99149
99292	99291
99354	99201-99205, 99212-99215, 99241-99245, 99324-99337, 99341-99350
99355	99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310, 99315-99318
99357	99356
99359	99358
99467	99466
99486	99485
99489	99487, 99488
99602	99601
99607	99605, 99606
0076T	0075T
0079T	0078T
0081T	0080T
0092T	22856
0095T	22864
0098T	22861
0159T	77058, 77059, C8903, C8904, C8905, C8906, C8907, C8908
0163T	22857
0164T	22865
0165T	22862
0172T	0171T
0174T	71010, 71020, 71021, 71022, 71030
0189T	0188T
0190T	67036
0196T	0195T
0205T	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564
0214T	0213T

TYPE I - CPT MANUAL DEFINES ALL ACCEPTABLE PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
0215T	0213T
0217T	0216T
0218T	0216T
0222T	0219T-0221T
0229T	0228T
0231T	0230T
0241T	0240T
0289T	65710, 65730, 65750, 65755
0290T	65710, 65730, 65750, 65755
0291T	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564,
0292T	0291T
0294T	33230, 33231, 33240, 33262-33264, 33249
0300T	0299T
0309T	22586

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TYPE II - CPT MANUAL DOES NOT DEFINE ANY SPECIFIC PRIMARY CODES

(BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
15777	"(List separately in addition to code for primary procedure)"
20985	"(List separately in addition to code for primary procedure)"
35400	"(List separately in addition to code for primary procedure)"
35681	"(List separately in addition to code for primary procedure)"
35697	"(List separately in addition to code for primary procedure)"
37186	"(List separately in addition to code for primary procedure)" As a TYPE II add-on code, CMS does not specify primary codes. The ACR/SIR recommended the following primary codes which may not be a listing of all possible primary codes: 35475, 37201, 37205, 37215, 37216, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 61630, 61635 (This ACR/SIR list may contain deleted codes)
37250	"(List separately in addition to code for primary procedure)" As a TYPE II add-on code, CMS does not specify primary codes. The ACR/SIR recommended the following primary codes which may not be a listing of all possible primary codes: 34800, 34802, 34803, 34804, 34805, 34900, 35471, 35472, 35476, 37200, 37201, 37202, 37203, 37204, 37205, 37206, 37207, 37208, 61624, 61626 (This ACR/SIR list may contain deleted codes)
38102	"(List separately in addition to code for primary procedure)"
38747	"(List separately in addition to code for primary procedure)"
44015	"(List separately in addition to code for primary procedure)"
44955	"(List separately in addition to code for primary procedure)"
47001	"(List separately in addition to code for primary procedure)"
47550	"(List separately in addition to code for primary procedure)"
48400	"(List separately in addition to code for primary procedure)"
49327	"(List separately in addition to code for primary procedure)"
49412	"(List separately in addition to code for primary procedure)"
49905	"(List separately in addition to code for primary procedure)"
58611	"(List separately in addition to code for primary procedure)"
61781	"(List separately in addition to code for primary procedure)"
61782	"(List separately in addition to code for primary procedure)"
61783	"(List separately in addition to code for primary procedure)"
75774	"(List separately in addition to code for primary procedure)" As a TYPE II add-on code, CMS does not specify primary codes. The ACR/SIR recommended the following primary codes which may not be a listing of all possible primary codes: 75600, 75605, 75625, 75630, 75635, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791 (This ACR/SIR list may contain deleted codes)
76125	"(List separately in addition to code for primary procedure)"
76937	"(List separately in addition to code for primary procedure)" As a TYPE II add-on code, CMS does not specify primary codes. The ACR/SIR recommended the following primary codes which may not be a listing of all possible primary codes: 36000, 36002, 36005, 36010, 36011, 36012, 36013, 36014, 36015, 36100, 36120, 36140, 36147, 36160, 36200, 36215, 36216, 36217, 36245, 36246, 36247, 36410, 36481, 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36575, 36576, 36578, 36580, 36582, 36583, 36584, 36585, 36589, 36590, 36595, 36597, 36598, 37182, 37183, 37200, 37210, 37215, 37216, 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 61623, 61630, 61635

TYPE II - CPT MANUAL DOES NOT DEFINE ANY SPECIFIC PRIMARY CODES**(BASED ON 2013 CPT MANUAL)**

ADD-ON CODE	PRIMARY CODE(S)
	"(List separately in addition to code for primary procedure)"
77001	As a TYPE II add-on code, CMS does not specify primary codes. The ACR/SIR recommended the following primary codes which may not be a listing of all possible primary codes: 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36575, 36576, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 36589, 36590
99100	"(List separately in addition to code for primary anesthesia procedure)"
99116	"(List separately in addition to code for primary anesthesia procedure)"
99135	"(List separately in addition to code for primary anesthesia procedure)"
99140	"(List separately in addition to code for primary anesthesia procedure)"
0054T	"(List separately in addition to code for primary procedure)"
0055T	"(List separately in addition to code for primary procedure)"

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TYPE III - CPT MANUAL DEFINES ONLY SOME, BUT NOT ALL, ACCEPTABLE SPECIFIC PRIMARY CODES (BASED ON 2013 CPT MANUAL)

ADD-ON CODE	PRIMARY CODE(S)
64727	64702-64726 “(List separately in addition to code for neuroplasty)” plus possibly other primary codes
88311	17311, 17313, 88302, 88304, 88305, 88307, 88309 “(List separately in addition to code for surgical pathology examination)” plus possibly other primary codes

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