



## 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](mailto: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](http://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 2025>
      - i. Treatment of contiguous structures of the same organ do not constitute different anatomic sites. < *MLN Fact Sheet*, 1783722 February 2025> See
      - b. During different patient encounters. < See MLN1783722 February 2025>
  - (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 2025>

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; See: Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 13275>

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>

#### 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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