

**Center for Medicaid and CHIP Services Technical Guidance on State  
Implementation of the Medicaid National Correct Coding Initiative Methodologies**

**Section 508 Compliant**

**5.6.16**

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Note: This edition of this technical guidance document for states supersedes prior versions of this document and supersedes prior individual notices that have been posted on the Medicaid Integrity Institute website on the RISSNET portal.

## **1.0 Sources of Information on the Centers for Medicare & Medicaid Services National Correct Coding Initiative in the Medicaid Program**

The Medicaid National Correct Coding Initiative (NCCI) webpage on the Medicaid.gov website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html> provides:

- basic information on the Centers for Medicare & Medicaid Services (CMS) NCCI in the Medicaid program;
- reference documents on the Medicaid NCCI program; and
- the Medicaid NCCI edit files and change-report files for the current calendar quarter.

This webpage includes links to the following reference documents on the Medicaid NCCI program:

- The *National Correct Coding Initiative Policy Manual for Medicaid Services* provides technical coding information that state Medicaid agencies, fiscal agents, and providers may use to understand the basis of specific NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs).
- The *Medicaid National Correct Coding Initiative Edit Design Manual* describes the file types and file formats for the Medicaid NCCI PTP edit files and MUE files and provides instructions for implementing these edits, including rules for adjudicating Medicaid claims.
- The *National Correct Coding Initiative Correspondence Language Manual for Medicaid Services* provides information that state Medicaid agencies and fiscal agents can use to respond to inquiries from providers concerning specific Medicaid NCCI PTP edits and MUEs.

Medicaid NCCI information and edit files for states only are provided in the “Medicaid NCCI Methodologies” folder on the Medicaid Integrity Institute (MII) website on the secure RISSNET portal. The subfolder “User Reference Documents” is a repository of technical guidance papers for states on the Medicaid NCCI methodologies. The MII website is administered by the Medicaid Integrity Group in the CMS Center for Program Integrity.

## **2.0 Requirements for State Implementation of the Medicaid National Correct Coding Initiative Methodologies**

Section 6507 of the Affordable Care Act requires states to use “compatible” NCCI methodologies in paying applicable Medicaid claims. The Center for Medicaid and CHIP Services (CMCS) requires that the Medicaid Management Information System (MMIS) in each state completely and correctly implement and use in paying applicable Medicaid claims:

- all six national Medicaid NCCI methodologies unchanged;<sup>1</sup>
- all four components of each Medicaid NCCI methodology;<sup>2</sup>
- the most recent quarterly Medicaid NCCI edit files for states;<sup>3</sup>
- the Medicaid NCCI edits in effect for the date of service on the claim line or claim;
- the claim-adjudication rules in the Medicaid NCCI methodologies;<sup>4</sup> and
- all modifiers for Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes needed for the correct adjudication of applicable Medicaid claims.<sup>5</sup>

The claim-adjudication rules and modifiers required by the Medicaid NCCI methodologies cannot be deactivated by states.

The Medicaid NCCI methodologies must be applied to applicable Medicaid claims from both waiver and non-waiver state Medicaid programs. However, for both waiver and non-waiver state Medicaid programs, a state can request CMS approval to deactivate individual Medicaid NCCI edits which conflict with state law, regulation, administrative rule, or payment policy.<sup>6</sup>

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<sup>1</sup> The six Medicaid NCCI methodologies are (1) a methodology with PTP edits for practitioner and ambulatory surgical center (ASC) services; (2) a methodology with PTP edits for outpatient services in hospitals (including services provided in emergency and radiology departments, observation units, clinics, and laboratories); (3) a methodology with PTP edits for durable medical equipment; (4) a methodology with MUEs for practitioner and ASC services; (5) a methodology with MUEs for outpatient services in hospitals; and (6) a methodology with MUEs for durable medical equipment.

<sup>2</sup> The four components of each Medicaid NCCI methodology are (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claim-adjudication rules for applying the edits; and (4) a set of rules for addressing provider appeals of denied payments for services billed based on the edits. Section 5.0 of this document describes the types of Medicaid claims that are subject to the Medicaid NCCI edits. The claim-adjudication rules in the Medicaid NCCI methodologies are specified in the most recent *Medicaid NCCI Edit Design Manual*. State Medicaid Director Letter #11-003 states CMS policy on provider appeals of denials of payment for HCPCS / CPT codes billed in Medicaid claims due to the Medicaid NCCI methodologies.

<sup>3</sup> These files are posted in the “Medicaid NCCI Methodologies” folder on the MII website on the RISSNET portal. States cannot use the Medicaid NCCI files posted on the Medicaid NCCI webpage on the Medicaid.gov website.

<sup>4</sup> Section 6507 of the Affordable Care Act made the Medicaid NCCI methodologies primary in state processing of Medicaid claims. This means that the claim-adjudication rules in the Medicaid NCCI methodologies should be applied prior to application of state PTP edits and units-of-service (UOS) edits in paying applicable Medicaid claims. These rules are specified in the *Medicaid National Correct Coding Initiative Edit Design Manual*.

<sup>5</sup> See sections 8.0-8.2 of this document.

<sup>6</sup> See section 7.4.2 of this document.

If a state or contractor Medicaid edit conflicts with a Medicaid NCCI edit, a state is to use the Medicaid NCCI edit, and not the state / contractor edit, unless the state receives CMS approval to deactivate the Medicaid NCCI edit.<sup>7</sup>

If permission to deactivate a Medicaid NCCI edit is not granted by CMS, that edit must be applied to all applicable Medicaid claims from the provider types described in section 5.3 of this document. States are not permitted to unilaterally decide which applicable Medicaid claims from those types of providers to apply the Medicaid NCCI edits to and which applicable Medicaid claims from those types of providers not to apply the Medicaid NCCI edits to.

States are required to implement, and use in paying all applicable Medicaid claims (regardless of the date of service), the new quarterly Medicaid NCCI edit files for states on the first day of every calendar quarter corresponding to the effective date of the files. New quarterly Medicaid NCCI edit files are complete replacements of prior Medicaid NCCI edit files. States cannot continue to use earlier Medicaid NCCI edit files for paying applicable Medicaid claims on and after the first day of a new calendar quarter.

If a state has not implemented the new quarterly Medicaid NCCI edit files in its MMIS by the first day of the second month of the new calendar quarter, then the state must reprocess with the new quarterly Medicaid NCCI edit files all claims processed with the Medicaid NCCI edit files from the previous calendar quarter on and after the first day of the new calendar quarter until the date the new quarterly Medicaid NCCI edit files for the new calendar quarter are implemented in its MMIS.

States are also required to continue to submit to their CMS Regional Office quarterly estimates of savings in Medicaid program costs due to application of the Medicaid NCCI methodologies in paying applicable Medicaid claims. States are to report these estimates using the template provided on the MII website on the RISSNET portal.

## **2.1 Appeals**

*States are not required to have a formal appeals process to address claim denials. However, states should ensure that providers have an adequate opportunity to alert them to potential errors associated with claim denials, including those generated by NCCI edits, and that providers have an avenue to resubmit claims or provide additional documentation to support their claims.*

## **3.0 State Use of Commercial Off-the-Shelf Software**

A state Medicaid agency may use a commercial off-the-shelf (COTS) software product to implement the Medicaid NCCI methodologies. CMS is neutral on the method a state uses to implement the Medicaid NCCI methodologies in its MMIS. CMS does not advocate any one

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<sup>7</sup> See section 7.4.2 of this document.

Medicaid NCCI implementation solution over any other Medicaid NCCI implementation solution.

It is up to each state Medicaid agency to decide which Medicaid NCCI implementation solution is best suited to its MMIS. However, each state Medicaid agency is responsible for ensuring that whatever method that it chooses to use in its MMIS is fully compliant with all federal requirements for state implementation of the NCCI methodologies.<sup>8</sup>

#### **4.0 Enhanced Federal Financial Participation for Medicaid Management Information Systems**

Section 1903(r) of the Social Security Act (SSA), as amended by section 6507 of the Affordable Care Act (ACA), describes the functionality of a state's MMIS system or a state's information retrieval and automated claims payment processing system. With the enactment of this section of the ACA, state MMISs must include Medicaid NCCI methodologies as part of their functionality. Section 1903(a)(3) of the SSA provides CMS with the authority to provide enhanced Federal Financial Participation (FFP) to states for the design, development, installation, and maintenance of the state's MMIS system.

Thus, in considering revisions to a state's MMIS, CMS is authorized to reimburse a state 90 percent of its costs to upgrade and update its MMIS to fully and correctly implement the Medicaid NCCI methodologies. However, this enhanced FFP is only applicable to the costs of upgrading / updating the components of the state's MMIS that are 100 percent owned by the state. Federal funds cannot be used for any MMIS component that is proprietary, i.e., partially or fully owned by a private entity.<sup>9</sup>

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<sup>8</sup> The only way to determine if a COTS software product completely and correctly implements the Medicaid NCCI methodologies is to conduct an audit of the product. Such an audit would need to determine if the COTS software product:

- includes the same six Medicaid NCCI methodology edit databases with the same effective and deletion dates;
- applies the Medicaid NCCI edits to all applicable Medicaid claims for the types of services required by the Medicaid NCCI methodologies;
- uses the claim-adjudication rules required for the Medicaid NCCI methodologies, including allowing for the appropriate use of modifiers; and
- provides an appeals process and patient protections as required by the Medicaid NCCI methodologies.

<sup>9</sup> A state can request enhanced FFP for the costs of upgrading / updating its MMIS to completely and correctly implement the Medicaid NCCI methodologies by completing, and submitting to its CMS Regional Office, Part I of the Medicaid NCCI Advance Planning Document (APD).

## **5.0 Scope of Application of the Medicaid NCCI Methodologies**

### **5.1 Types of Medicaid Claims that are Applicable to the Medicaid NCCI Methodologies**

The Medicaid NCCI methodologies are applicable only to Medicaid fee-for-service (FFS) claims which are submitted with, and reimbursed on the basis of, HCPCS codes and CPT codes.

This includes:

- claims reimbursed on a FFS basis in state Medicaid managed care programs and
- Medicare Part C Dual-Eligible Special Needs Plan (D-SNP) claims received from Medicare Advantage Part C Plans that have a D-SNP program.

### **5.2 Types of Medicaid Claims that are not Applicable to the Medicaid NCCI Methodologies**

The Medicaid NCCI methodologies are not applicable to three categories of Medicaid claims:<sup>10</sup>

- Medicaid claims which are not submitted using HCPCS / CPT codes, e.g., claims which are submitted using revenue codes, Common Dental Terminology (CDT) codes, and National Drug Codes (NDCs);
- Medicaid claims which are not paid on a fee schedule that is based on the HCPCS / CPT codes that are submitted, e.g., claims which are paid based on a flat encounter / visit fee, a capitation contract, or a full, retrospective cost report; and
- Medicaid claims from inpatient and residential facilities, e.g., services to inpatients provided by hospitals and services to residents provided by nursing homes.

### **5.3 Types of Applicable Medicaid Claims States are Required to Apply the Medicaid NCCI Methodologies to<sup>11</sup>**

Under the authority of section 6507 of the Affordable Care Act, State Medicaid Director Letter #10-107 requires states to use the Medicaid NCCI methodologies for paying applicable Medicaid

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<sup>10</sup> For types of Medicaid claims for which CMS designates the Medicaid NCCI methodologies as “not applicable”, states do not need to notify CMS that they will not be using the Medicaid NCCI methodologies to reimburse these types of claims and do not need to request CMS approval to deactivate the Medicaid NCCI edits for these types of claims.

<sup>11</sup> This section defines the types of claims subject to the Medicaid NCCI edits, one of the four components of the Medicaid NCCI methodologies.

FFS claims which are submitted with, and reimbursed on the basis of, HCPCS codes and CPT codes from the following types of providers:

- practitioners and ambulatory surgical centers;
- services provided to outpatients in hospitals (including services rendered in emergency rooms, observation units, laboratories, and radiology departments, and other diagnostic and therapeutic services); and
- providers of durable and home medical equipment.

#### 5.4 Managed Care<sup>12</sup>

State Medicaid managed care programs include three forms of Medicaid managed care: primary care case management, limited benefit plans, and managed care organizations (MCOs). Application of the Medicaid NCCI methodologies to primary care case management and MCOs are discussed below. The same principles apply to limited benefit plans as for MCOs, but such plans do not provide comprehensive Medicaid benefits.

**Table 1: Application of the Medicaid NCCI Methodologies to Two Principal Forms of Medicaid Managed Care**

	Primary Care Case Management	Managed Care Organization	Managed Care Organization
Scope of Monthly State Payment	Case management services only	Most Medicaid-covered services	Most Medicaid-covered services
Who Pays Providers of Medicaid-Covered Services	State	Managed Care Organization	Managed Care Organization
Type of Data Submitted by Providers	Claims	Claims	Encounters
Method of Paying Providers of Medicaid-Covered Services	Fee-for-Service	Fee-for-Service	Sub-Capitation / Bundled / Global Payment
Use of Medicaid NCCI Methodologies	Required	Optional	Optional

<sup>12</sup> The information in this section applies to organizations in their role as a Managed Care Organization (MCO) contracted to a state Medicaid agency. If a state Medicaid agency contracts with the same organization as an Administrative Services Organization (ASO), to adjudicate Medicaid fee-for-service claims for state Medicaid beneficiaries who are not enrolled on a capitated basis in the MCO, the organization must use the Medicaid NCCI methodologies to adjudicate these Medicaid fee-for-service claims.

### **5.4.1 Primary Care Case Management**

In primary care case management, the state Medicaid agency pays a monthly fee to a provider or group of providers to provide case management services to Medicaid beneficiaries who are assigned to a Primary Care Case Manager (PCCM). The PCCM also provides primary care services to the assigned Medicaid beneficiaries. The state Medicaid agency reimburses on a FFS basis the PCCM for the primary care services provided by the PCCM and the providers for other covered Medicaid services provided to these assigned beneficiaries.

For this form of Medicaid managed care, the state Medicaid agency is required to use the Medicaid NCCI methodologies in processing the FFS claims that it receives from these providers of primary care and other covered Medicaid services. Denials of payment for these Medicaid claims that result from the Medicaid NCCI edits should be characterized as denials of payment due to the Medicaid NCCI edits.

State Medicaid agencies are required to report to CMS quarterly estimates of savings in Medicaid program costs that result from the application of the Medicaid NCCI methodologies to FFS claims that the agency processes under the PCCM form of managed care. These estimates of savings should be aggregated with estimates of savings from the application of the Medicaid NCCI methodologies to non-managed care FFS claims and included in a state's quarterly reports to CMS on estimated savings in Medicaid program costs due to application of the Medicaid NCCI methodologies to the state's Medicaid FFS claims.

### **5.4.2 Managed Care Organizations**

In a risk-based managed-care arrangement, the state Medicaid agency pays a Managed Care Organization (MCO) a monthly prepaid amount for each Medicaid enrollee, which covers most Medicaid-covered services provided to each enrollee. The MCO may reimburse those who provide covered services to the Medicaid enrollees on a FFS, sub-capitated, or other bundled / global payment basis.

The state Medicaid agency may choose to:

- require an MCO to use the Medicaid NCCI methodologies in processing the claims that an MCO pays on a FFS basis and / or
- apply the Medicaid NCCI methodologies to the encounter data from the MCO, if it wishes to do so and if the encounter data contain the necessary HCPCS codes and CPT codes.

If a state Medicaid agency chooses to require an MCO to use Medicaid NCCI methodologies in processing any claims that the MCO pays on a FFS basis, or if an MCO that pays claims on a FFS basis chooses to use the Medicaid NCCI methodologies, even though there is no requirement to do so, those denials should be characterized as denials of payment due to the Medicaid NCCI edits.

If a state Medicaid agency chooses to apply the Medicaid NCCI methodologies to the encounter data from an MCO (or allows an MCO to do so), the state does so at its own risk because the NCCI methodologies were not designed for such use. If a state Medicaid agency does so, the edits are now considered to be “state” edits and are no longer “NCCI” edits. Any denials of payment to Medicaid managed care providers due to application of the Medicaid NCCI edits cannot be attributed to the Medicaid NCCI edits and must be attributed instead to “state” edits. A state is not required to report to CMS quarterly state estimates of savings in Medicaid program costs due to application of the Medicaid NCCI methodologies to FFS claims paid by MCOs or to encounter data from MCOs. However, CMS encourages state Medicaid programs to report such estimates to CMS.

If a state does so, the state should separately report to CMS (1) the quarterly state estimates of savings in Medicaid program costs due to application of the Medicaid NCCI methodologies to the FFS claims paid by the state Medicaid program and (2) the state’s quarterly estimates of savings in Medicaid program costs due to application of the Medicaid NCCI methodologies to the claims and / or encounter data from the MCOs in the state.

## **5.5 Types of Applicable Medicaid Claims which are Optional for State to Apply the Medicaid NCCI Methodologies to**

State Medicaid agencies have the option to use the Medicaid NCCI methodologies in reimbursing applicable Medicaid claims from other types of providers of outpatient services. States do not have to request CMS approval to not apply the Medicaid NCCI methodologies to Medicaid claims from these types of providers. However, if a state chooses to apply the Medicaid NCCI edits to Medicaid claims from these providers, then the state should include in its quarterly cost savings reports to CMS the estimated savings in Medicaid program costs due to use of the Medicaid NCCI methodologies in paying these claims.

### **5.5.1 Nonhospital-Based Testing Facilities**

These include, but are not limited to, physician office-based laboratories, independent clinical laboratories, independent radiology facilities, and independent diagnostic testing facilities.

### **5.5.2 Other Types of Providers of Outpatient Services**

These include, but are not limited to, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Mental Health Centers (CMHCs), comprehensive outpatient rehabilitation facilities, free-standing dialysis centers, chemical dependency treatment centers, independent ambulance companies, and providers of outpatient services in homes, schools, hospices, and nursing homes which are not practitioners.

## **6.0 Application of the Medicaid NCCI Methodologies to Different Types of Applicable Medicaid Claims**

The table below provides guidance to states on the Medicaid NCCI methodology that should be applied to applicable Medicaid claims for each type of Medicaid claim and each type of provider.

State Medicaid agencies are required to apply the Medicaid NCCI methodologies to applicable Medicaid claims from the first five types of providers listed in the table below.

It is optional for state Medicaid agencies to apply the Medicaid NCCI methodologies to applicable Medicaid claims from the last two types of providers listed in the table below.

### **Table 2: Application of the Medicaid NCCI Methodologies to Different Types of Applicable Medicaid Claims**

Type of Provider	CMS 1500 / 837P Claim Form or Equivalent Submitted	CMS 1500 / 837P Claim Form or Equivalent Submitted	UB 04 / 837I Claim Form or Equivalent Submitted
	Rendering Practitioner Identified <sup>13</sup>	Rendering Practitioner Not Identified <sup>10</sup>	
Physician Practitioner <sup>14</sup>	PRA <sup>15</sup>	PRA	OPH <sup>16</sup>
Nonphysician Practitioner <sup>17</sup>	PRA	PRA	OPH
Ambulatory Surgical Center (ASC)	PRA	PRA	PRA
Outpatient Services in Hospitals <sup>18</sup>	OPH	OPH	OPH
Durable / Home Medical Equipment <sup>19</sup>	DME <sup>20</sup>	DME	DME
Nonhospital-Based Testing Facilities <sup>21</sup>	PRA	PRA	PRA
Other Providers of Outpatient Services <sup>22</sup>	PRA	OPH	OPH

<sup>13</sup> With the National Provider Identifier (NPI) or equivalent.

<sup>14</sup> Physician practitioners include doctors of medicine and osteopathy, podiatrists, optometrists, chiropractors, and dentists. This includes applicable Medicaid claims for outpatient services and for services provided to inpatients in hospitals and to residents of nursing homes.

<sup>15</sup> The Medicaid NCCI methodologies with PTP edits and MUEs for practitioner and ambulatory surgical center (ASC) services.

<sup>16</sup> The Medicaid NCCI methodologies with PTP edits and MUEs for outpatient services in hospitals.

<sup>17</sup> Examples of nonphysician practitioners include nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse midwives, physician assistants, clinical psychologists, clinical social workers, physical therapists, occupational therapists, and speech-language pathologists. This includes applicable Medicaid claims for outpatient services and for services provided to inpatients in hospitals and to residents of nursing homes.

<sup>18</sup> E.g., services provided to outpatients in emergency rooms, observation units, clinics, laboratories, and radiology departments in hospitals and other diagnostic and therapeutic services provided to outpatients in hospitals.

<sup>19</sup> CMS requires states to apply the Medicaid NCCI Durable Medical Equipment (DME) methodologies to Medicaid claims for durable medical equipment, prosthetics, orthotics, and supplies submitted by all providers of outpatient services. Identical edits for the Medicaid NCCI DME methodologies are found in standalone DME edit files and in the PRA and OPH edit files. States have the option to use the DME edits from any of these edit files to apply to Medicaid DME claims, as the DME edits are the same within the three PTP-edit files and within the three MUE files.

<sup>20</sup> The Medicaid NCCI methodologies with PTP edits and MUEs for durable / home medical equipment.

<sup>21</sup> E.g., physician office-based laboratories, independent clinical laboratories, independent radiology facilities, and independent diagnostic testing facilities.

<sup>22</sup> E.g., Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Mental Health Centers (CMHCs), comprehensive outpatient rehabilitation facilities, free-standing dialysis centers, chemical

## 7.0 Edits

### 7.1 Complete Edit Files

States are required to use the Medicaid NCCI edit files for processing and paying applicable Medicaid claims. The Medicare NCCI edit files cannot be used as a substitute for processing and paying Medicaid claims because the differences between the two sets of NCCI edit files are significant and are growing over time.

Unlike the Medicare NCCI edit files, the Medicaid NCCI edit files contain no confidential edits. This includes the Medicaid NCCI edit files for states that are posted on the MII website on the secure RISSNET portal.

The existence of a Medicaid NCCI edit for a HCPCS / CPT code does not mean that a state Medicaid program is required to cover that code or that the code is covered by any state Medicaid program or by all state Medicaid programs.

All PTP edits contained in the final quarterly Medicaid NCCI edit files for states that are posted on the MII website on the RISSNET portal are contained in the Medicaid NCCI edit files for the current calendar quarter that are posted on the Medicaid NCCI webpage on the Medicaid.gov website.

The final quarterly Medicaid NCCI MUE files that are posted for states on the MII website contain both the MUEs that are currently in effect and the MUEs that have been deleted and are no longer in effect. A state's MMIS should apply the MUEs that are not currently active to Medicaid claims with dates of service in prior calendar quarters when these MUEs were in effect.

However, the quarterly Medicaid NCCI MUE files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website contain only the MUEs that are in effect for claims processed and paid in the current calendar quarter. The files do not contain the MUEs that are no longer in effect.

The quarterly Medicaid NCCI edit files for states on the MII website contain a few fields for each type of edit that the quarterly Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website do not contain. More information is contained in the *Medicaid NCCI Edit Design Manual*.

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dependency treatment centers, independent ambulance companies, and providers of outpatient services in homes, schools, hospices, and nursing homes which are not practitioners.

**Table 3: Differences in the Fields in the Medicaid NCCI Edit Files Posted on the Medicaid NCCI Webpage on the Medicaid.gov Website and on the Medicaid Integrity Institute (MII) Website on the RISSNET Portal**

Fields	PTP Edits	MUEs
In files on both the Medicaid.gov and MII websites	Col 1 code, Col 2 code, Eff Date, Del Date, CCMI	Code, MUE value
Only in files on the MII website	CLEID	CLEID, Eff Date, Del Date, Pub Ind
Only in files on the Medicaid.gov website	Edit rationale <sup>23</sup>	Edit rationale

Approximately 15 days before the beginning of a new calendar quarter, CMS posts the final, complete, quarterly Medicaid NCCI files on the MII website on the RISSNET portal. The state is required to implement the edits in those files beginning with claims processed on the first day of the calendar quarter. If the state has not implemented the edits in those files by the beginning of the second month of the calendar quarter using the new quarterly edit files, it must reprocess claims that were processed from the first day of the calendar quarter to the day that the edits from the new files were first applied. For example, if the edits in the January 2014 edit files were not implemented until February 7, 2014, the state must reprocess claims that were previously processed from 1.1.14 through 2.6.14.

A state Medicaid agency must use the most recent final quarterly Medicaid NCCI files that have been posted on the MII website on the RISSNET portal for processing and paying applicable Medicaid claims. For example, a state must use the Medicaid NCCI edits in Medicaid NCCI edit files for the first quarter of 2014 for claims that are processed and paid from 1.1.14 through 3.31.14, regardless of the date of service on the claim. In addition, a state Medicaid agency cannot use the quarterly Medicaid NCCI edit files posted on the Medicaid NCCI webpage on the Medicaid.gov website because these files do not contain all of the fields that are contained in the final quarterly Medicaid NCCI edit files that are posted on the MII website.

If a state's MMIS is processing a Medicaid claim with a date of service in an earlier calendar quarter, the MMIS should process the claim with the Medicaid NCCI edit files for the current calendar quarter that are posted for states on the MII website, not with the Medicaid NCCI edit files for the earlier calendar quarter.

The final quarterly Medicaid NCCI edit files for the current calendar quarter that are posted for states on the MII website contain the effective date and deletion date (if applicable) of every past and present Medicaid NCCI edit. If a Medicaid NCCI edit is no longer in effect in the current calendar quarter, but was in effect in the calendar quarter for the date of service of the Medicaid claim, the Medicaid NCCI edit should be applied to the claim.

Two or three dates determine whether a Medicaid NCCI edit is implemented in processing a Medicaid claim. Every Medicaid NCCI edit in a quarterly Medicaid NCCI edit files for states

<sup>23</sup> Exception: The PTP edit rationale is also included in the Fixed-Width ASCII text files on the MII website, but not in the Tab-Delimited ASCII text files or the Excel files on the MII website.

contains an effective date. If a Medicaid NCCI edit has been deleted, the deletion date for the edit is contained in every subsequent quarterly Medicaid NCCI edit file for states.

Every quarterly Medicaid NCCI edit file contains a version date, which is the first day of the calendar quarter the file is effective for. The version date defines the period of time during which claims processed by a state are subject to the edits in that version. It does not have a direct relationship with the date of service of the claim. For example, the version date for the edits contained in the state Medicaid NCCI edit files for the second quarter of 2014 is April 1, 2014. These edits should be applied to claims that are processed by a state between April 1, 2014, and June 30, 2014.<sup>24</sup>

If a claim falls within the range of processing dates for that version of the Medicaid NCCI edit files, then the edit should look at the date of service on the claim line and only apply the Medicaid NCCI edit if the date of service is on or after the effective date of the edit and on or before the deletion date of the edit (if applicable).

For example, if the date of service on a claim was 12.27.13 and the claim is processed on 1.3.14, then the Medicaid NCCI edit files with a version date of 1.1.14 should be used in processing the claim. However, Medicaid NCCI edits with an effective date of 1.1.14 contained in the Medicaid NCCI edit files with a version date of 1.1.14 should not be applied to that claim. Medicaid NCCI edits with a deletion date before 12.27.13 contained in the Medicaid NCCI edit files with a version date of 1.1.14 should also not be applied to the claim.

If a state Medicaid agency uses a COTS product or service to process and pay its Medicaid claims, the state Medicaid agency must ensure that the COTS product or service fully and correctly implements the Medicaid NCCI methodologies. This includes use of the most recent final quarterly Medicaid NCCI edit files that are posted for states on the MII website. COTS vendors do not have direct access to this website or to these files. States are notified of postings of all Medicaid NCCI information and edit files on the MII website on the RISSNET portal in the *MII Messenger* and through the listserv of the National Medicaid Electronic Data Interchange Healthcare (NMEH) NCCI Subworkgroup.

### **7.1.1 Sharing of State Medicaid NCCI Edit Files by States with Other Entities**

Access to the complete quarterly Medicaid NCCI edit files that are posted on the Medicaid Integrity Institute (MII) website on the RISSNET portal is limited to a state's Medicaid agency. These state Medicaid NCCI edit files contain information that is not included in the Medicaid NCCI edit files that are available to the public on the Medicaid NCCI webpage on the Medicaid.gov website, i.e., MUEs that are no longer in effect, their effective date and deletion date, the effective date of current MUEs, and the Correspondence Language Identification Number (CLEID) for PTP edits and MUEs.

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<sup>24</sup> If a state does not implement new quarterly Medicaid NCCI edit files on the version date of these files, these dates will be different.

A state Medicaid agency may share these quarterly state Medicaid NCCI edit files when they are posted on the MII website on the RISSNET portal with the contracted fiscal agent that processes its fee-for service claims or with any of its contracted Medicaid managed-care entities that is utilizing the Medicaid NCCI methodologies in its processing of claims or encounter data, if appropriate confidentiality agreements are in place. The state Medicaid agency, its fiscal agent, and its managed-care entities may also share those files at that time with any contractor or subcontractor (including, but not limited to, COTS software vendors) which is assisting with the implementation of the state's Medicaid NCCI program in the processing of claims or encounter data, if appropriate confidentiality agreements are in place. The state Medicaid agency need not have a direct contract with such vendors.

Information contained in these state Medicaid NCCI edit files that is not available to the general public in the Medicaid NCCI edit files on the Medicaid NCCI webpage on the Medicaid.gov website should never be used for non-Medicaid purposes. Information about quarterly changes in the Medicaid NCCI edit files which is posted in the change-report files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website at the beginning of each calendar quarter may not be released prior to this time.

The state Medicaid agency, its fiscal agent, and its managed-care entities are expected to have confidentiality agreements in place with any contractor or subcontractor (including, but not limited to, COTS software vendors) which is assisting with the implementation of the state's Medicaid NCCI program to ensure that the restrictions concerning the sharing of Medicaid NCCI edits are clearly understood by all parties. At a minimum, the following elements should be included in the confidentiality agreements and should also be followed by the state Medicaid agency:

- No disclosure to any parties not involved in the implementation of the quarterly state Medicaid NCCI edit files of any information contained in those files prior to the start of the new calendar quarter.
- After the start of the new calendar quarter, Medicaid MCOs and their contractors may disclose only non-confidential information that is also available to the general public about the Medicaid NCCI edit files on the Medicaid NCCI webpage on the Medicaid.gov website.
- The contractors of state Medicaid agencies and Medicaid MCOs agree not to use any non-public information from the quarterly state Medicaid NCCI edit files for any business purposes unrelated to the implementation of the Medicaid NCCI methodologies in a state.
- New, revised, or deleted Medicaid NCCI edits may not be published or otherwise shared with individuals, medical societies, or any other entity not involved with implementation of the Medicaid NCCI methodologies and not covered by the confidentiality agreement prior to posting of the Medicaid NCCI edits on the Medicaid NCCI webpage on the Medicaid.gov website (typically, the first day of the calendar quarter).

- New, revised, or deleted Medicaid NCCI edits may not be implemented in a state’s Medicaid program prior to the first day of the calendar quarter.
- New, revised, or deleted Medicaid NCCI edits may not be implemented or used by reviewers in non-Medicaid programs prior to posting of the Medicaid NCCI edit files on the Medicaid NCCI webpage on the Medicaid.gov website (typically, the first day of the calendar quarter).
- After the new quarterly Medicaid NCCI edit files have been posted on the Medicaid NCCI webpage on the Medicaid.gov website, information relating to individual edits or limited ranges of edits that is in the Medicaid NCCI edit files on the MII website on the RISSNET portal and that is not contained in the Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website may be released in response to inquiries from individuals, medical societies, or other non-Medicaid entities. However, there may be no broad release to individuals, medical societies, or other non-Medicaid entities of information that is not contained in the Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website.
- After the Medicaid NCCI edit files have been posted on the Medicaid NCCI webpage on the Medicaid.gov website, information in those files may be used by any entity for non-Medicaid purposes. However, information that is in the Medicaid NCCI edit files on the MII website on the RISSNET portal and that is not in the files posted on the Medicaid NCCI webpage on the Medicaid.gov website may not be used at any time for non-Medicaid purposes.
- State Medicaid agencies should impose penalties, up to and including loss of contract, for violations of this confidentiality agreement.

### ***7.1.2 Medicaid-only NCCI Edits***

*Most Medicaid NCCI edits are derived from Medicare NCCI edits. However, there are some edits that are unique to Medicaid NCCI – typically either because the service or item is not covered or not separately payable by Medicare or because Medicare NCCI does not have one of the Medicaid methodologies (i.e., DME PTP edits). Proposed new Medicaid-only edits are sent for comment to the states and to appropriate national healthcare organizations (NHOs).*

*Once each quarter, CMS will post files with proposed Medicaid-only NCCI edits to the Medicaid Integrity Institute (MII) website on the RISSNET portal. States will be notified of the posting by a notice in the MII Messenger and the listserv of the National Medicaid Electronic Data Interchange Healthcare (NMEH) NCCI Subworkgroup. The target date for implementation of the edits will be two quarters later. For example, the target implementation for edits that are proposed in January will be the July quarterly update. (These files do not contain proposed*

*Medicare NCCI edits that will be included in the final Medicaid NCCI edit files for that calendar quarter.)*

*The proposed edits and the accompanying cover memo contain confidential information that should not be shared with the general public, state medical societies, or other individuals or entities not performing contracted work on the state fee-for-service Medicaid program. If a state shares the edits with Medicaid contractors who are assisting with implementation of the NCCI program, the following restrictions apply: Prior to their effective date, the edits should not be published, the edits should not be utilized by any reviewer for non-Medicaid purposes, and the edits should not be implemented by state Medicaid agencies. The state should not publish an article related to these edits because significant changes, including changes in the implementation date, could be made prior to implementation.*

*The files will be posted in an Excel 2007 / 2010 format. The file names will be:*

*MCD\_State\_Comment\_Process\_PTP\_mm-dd-yyyy.xlsx*

*MCD\_State\_Comment\_Process\_MUE\_mm-dd-yyyy.xlsx*

*If there are multiple files for PTP edits and / or MUEs, the file names will have an additional numerical indicator – e.g., PTP-1, PTP-2, MUE-1, MUE-2. Each Excel file may contain multiple tabs.*

*The files will be accompanied by a cover memo that provides a general description of the edits and the process for submitting comments.*

*The PTP State Comment Process files will be presented in one of four possible formats, depending on the number of individual edits in a particular group of edits:*

- *Format (a) lists every edit individually and contains the following columns:*
  - *Column 1 HCPCS / CPT Code*
  - *Column 1 Code Descriptor*
  - *Column 2 HCPCS / CPT Code*
  - *Column 2 Code Descriptor*
  - *Correct Coding Modifier Indicator (CCMI) Value*
  - *Edit Rationale*
- *Format (b) has a list of Column 1 and Column 2 codes and their descriptors with the explanation that each Column 1 code is paired with each Column 2 code. The CCMI values and edit rationales that apply to all the edits for a particular Column 2 code are listed in the columns related to that Column 2 code.*
- *Format (c) has a list of HCPCS/CPT codes and their descriptors with the explanation that each code is paired with every code below it in the list. The code that is higher in the list will be Column 1 code and the codes that are lower in the list will be the Column 2 codes. The CCMI values and rationales that apply to all the edits for a particular Column 1 code are listed in the columns related to that Column 1 code.*

- *Format (d) lists a new HCPCS/CPT code and a current code to which the new code is crosswalked. For every existing PTP edit that contains a current code listed in the table, a new PTP edit will be added that substitutes the new code for the current code.*

*The CCMI column in each PTP edit file identifies in which edit set(s) the edit will be included – Practitioner (PRA), Outpatient Hospital (OPH), or Durable Medical Equipment (DME). For example, an entry of 0/0/NA (NA = not applicable) indicates that the edit will be included in the PRA and OPH edit sets with a CCMI of “0”, but will not be included in the DME edit set. If a new or revised CCMI is being proposed in an edit set, but an existing CCMI is being retained in another edit set, this will be indicated by NC (no change). For example, an entry of NC/1/1 indicates that the existing PRA CCMI will not be changed but a new or revised CCMI of “1” is being proposed in the OPH and DME edit sets.*

*If format (b) or (c) is used, that is noted at the top of the table. Formats (b) and (c) are used to simplify the presentation of the proposed edits. However, in the final NCCI edit files, each resulting new or revised edit will be individually listed in a separate row.*

*The MUE State Comment Process files will contain the following columns:*

- *HCPCS / CPT Code*
- *Code Descriptor*
- *MUE Value*
- *Edit Rationale*

*The MUE Value column in each MUE file identifies in which edit set(s) the edit will be included – PRA, OPH, or DME. For example, an entry of 1/1/NA (NA = not applicable) indicates that the edit will be included in the PRA and OPH edit sets with an MUE value of “1”, but will not be included in the DME edit set. If a new or revised MUE is being proposed in an edit set, but an existing MUE is being retained in another edit set, this will be indicated by NC (no change). For example, an entry of NC/0/NA indicates that the existing PRA MUE will not be changed but a new or revised MUE of “0” is being proposed in the OPH edit set and there is no MUE in the DME edit set.*

*States will have 60 days from the date of posting to review and comment on the proposed edits. If a state disagrees with the proposed edits, it should send its comments in writing to the NCCI contractor, either by email, mail, or by fax. The pertinent addresses and phone numbers will be included in the cover memo that will be posted along with the proposed edit files.*

*The review of, and comment on, the proposed edits should consider the appropriateness of the edits based on NCCI coding policies. If a state disagrees with the edits, it must submit its comments in writing. The comments from the state must clearly identify the edits that are being challenged. If the state is requesting that the edit not be established, the comments should provide an explanation for that position. If the state thinks that the CCMI should be different, it should explain its rationale.*

*Comments that are received will be forwarded to, and reviewed by, CMS. A final determination will be made by CMS on whether to proceed with implementation of the edit.*

*States should also review the proposed Medicaid-only NCCI edits to determine if there are any conflicts with state laws, regulations, administrative rules, or payment policies. If there are conflicts with state laws, regulations, or administrative rules, the state may request CMS approval to deactivate individual Medicaid NCCI edits. If there are conflicts with a state's current payment policy, the state can consider making changes to those policies prior to the scheduled implementation of the edits or may request CMS approval to deactivate individual Medicaid NCCI edits. Information about submitting deactivation requests is found in Section 7.4.2.*

*For PTP edits, if a state's claims processing system is set so that the column 2 code in a PTP edit will deny even if the column 1 code is denied for other reasons, it is recommended that the state request deactivation of PTP edits in which the column 1 code is never covered, in order to prevent unintended denial of the column 2 code. If a state's claims processing system is set so that the PTP edit will be bypassed if the column 1 code is denied for other reasons, it is not necessary to request deactivation of PTP edits in which the column 1 code is never covered. It is also not necessary to request deactivation of edits in which just the column 2 code is never covered.*

*States should allow sufficient time for the review of deactivation requests by CMS prior to the scheduled implementation of the new and revised Medicaid NCCI edits.*

*If a state has any technical questions regarding the state comment edit files, it should contact Correct Coding Solutions. Specific contact information will be included in the cover memo.*

## **7.2 Change Report Files**

Change Report files identify added, deleted, and revised PTP edits and MUEs for a calendar quarter. Approximately 15 days before the beginning of a new calendar quarter, CMS posts the Change Reports for that quarter on both the MII website on the RISSNET portal and the Medicaid NCCI webpage on the Medicaid.gov website. The reports posted on both websites are identical.

The fields on the PTP edit Change Reports are: Code 1, Code 2, Correct Coding Modifier Indicator. The fields on the MUE Change Reports are: Code, MUE Value.

A state Medicaid agency should not use the Medicaid NCCI Change Report files to make individual changes in its earlier Medicaid NCCI edit files to update these files. The Medicaid NCCI edit files posted on the MII website on the RISSNET portal for each new calendar quarter are complete replacements of the Medicaid NCCI edit files for prior calendar quarters.

### **7.3 Categories of Edits and Order of Application to Applicable Medicaid Claims**

There are four categories of edits for processing and paying Medicaid claims:

- Medicaid NCCI PTP edits and MUEs
- State-specific screening edits
- State-specific PTP edits and units-of-service (UOS) edits which address services rendered on the same date of service
- Other state-specific edits

CMS requires states and contracted vendors to apply the three categories of state-specific edits in processing and paying applicable Medicaid claims according to the instructions below.

#### **7.3.1 State-Specific Screening Edits Which Must Be Applied Before the Medicaid NCCI Edits**

Examples (not all-inclusive):

- Required information is missing
- Invalid entries (e.g., invalid HCPCS / CPT codes, modifiers that are inappropriately appended to a HCPCS / CPT code)
- The patient was enrolled in the state's Medicaid program on the date of service
- The provider was a valid provider in the state's Medicaid program on the date of service
- Duplicate claim / claim line

#### **7.3.2 State-Specific PTP Edits and UOS Edits Which Address Services Rendered on the Same Date of Service Which Must Be Applied After the Medicaid NCCI Edits**

Procedure-to-Procedure (PTP) edits are edits in which payment of one code is denied because another code is billed by the same provider for the same date of service and paid. The codes may be billed on the same claim or on different claims. The edit may be an automated edit or an edit that suspends a claim for manual review.

Examples (not all-inclusive):

- Bundling edits in which a comprehensive code is billed and paid and a component code is billed, but payment is denied
- Global-surgery edits and obstetrical edits addressing services performed on the same date of service
- Incompatible and / or mutually-exclusive procedures.

Units-of-service (UOS) edits are edits in which there is a potential that only some of the submitted UOS will be paid. The edit may address services billed on a single claim line or on different lines of the same claim or on different claims. The edit may be an automated edit or an edit that suspends a claim for manual review.

Examples (not all-inclusive):

- Cutback edits addressing a single date of service
- Edits for services that require prior (service) authorization and for which more than one UOS could be authorized and the authorization is for a single date of service
- Medical-necessity or utilization-review edits addressing services provided on the same date of service.

### **7.3.3 Other State-Specific Edits Which May Be Applied Either Before or After the Medicaid NCCI Edits**

Examples (not all-inclusive):

- PTP edits addressing services provided on multiple / different dates of service, e.g., global-surgery edits and obstetrical edits addressing follow-up visits
- UOS / cutback edits addressing more than a single date of service
- Benefit-limit edits addressing more than a single date of service
- Services that require prior authorization and for which more than one UOS could be authorized and the authorization addresses more than a single date of service
- Services that require prior (service) authorization and which would always be for one UOS
- Edits which:
  - determine whether the state's Medicaid program covers the service billed for that Medicaid beneficiary on that date of service and
  - always result in either complete denial of payment or complete payment for the service
- Medical-necessity edits and utilization-review edits which always result in complete denial of payment or complete payment of the submitted UOS (e.g., diagnosis, gender, age)
- *Medical-necessity edits and utilization-review edits which address services provided on more than a single date of service.*
- Bundling edits in which the component codes are billed, but the comprehensive code is not billed
- Edits for third-party liability
- Pricing edits – as long as the edit does not have the potential of reducing the allowed / paid UOS.

This sequencing option applies to these types of edits regardless of whether the edit is an automated edit or an edit that suspends a claim for manual review.

If one of these edits is applied before the Medicaid NCCI edits and it results in the payment of only some of the submitted UOS, then the payable / cutback UOS should be presented to the Medicaid NCCI edits, not the submitted UOS.

## **7.4 State Options Regarding Individual Medicaid NCCI Edits**

### **7.4.1 Manual Claim Review and “Individual Case Exception” for a Medicaid NCCI Edit**

Payments for HCPCS / CPT codes billed on Medicaid claims must be denied, if denied by a Medicaid NCCI edit. A provider which has been denied payment for a code billed on a Medicaid claim due to a Medicaid NCCI edit can resubmit the claim with revised coding for which payment will not be denied by Medicaid NCCI edits. Another option for the provider is to submit documentation to justify payment in that individual case.

Medicaid PTP edits and MUEs are designed to address the vast majority of Medicaid claim submissions, but not always 100 percent of all Medicaid claim submissions. However, a state Medicaid agency can manually review a Medicaid claim and make an “individual case exception” to a Medicaid NCCI edit.

A state Medicaid agency may override a denial of payment for a Medicaid claim resulting from any Medicaid PTP edit or MUE, if the provider submits appropriate documentation and manual review of the claim verifies that the service or item was coded correctly, that it was medically necessary, and that payment is not included in the payment for some other service or item. Depending on the policy of the state’s Medicaid agency, documentation to justify an “individual case exception” may be submitted by a provider:

- at the time of initial adjudication of the claim;
- with resubmission of the claim following initial denial of payment for the claim by a Medicaid NCCI edit; or
- using the state’s existing Medicaid payment appeals process.

An “individual case exception” for a Medicaid NCCI edit is different than a deactivation of a Medicaid NCCI edit. An “individual case exception” involves overriding a single Medicaid NCCI edit after a claim has been manually reviewed. Deactivation requires reprogramming a state’s MMIS, so that a Medicaid NCCI edit will not be applied to all of a state’s Medicaid claims or to Medicaid claims from a specific type of provider.

## **7.4.2 Deactivation of Individual Medicaid NCCI Edits for One State<sup>25</sup>**

If a state finds that one or more Medicaid NCCI edits conflict with a state law, regulation, administrative rule, or payment policy, the state can consider making changes to its policies prior to the scheduled implementation of the edits. If the state does not wish to do so, the state can request through its CMS Regional Office CMS approval to deactivate that edit or those individual edits. The first time that a state wishes to request CMS approval to deactivate any Medicaid NCCI edits, the state must submit to its CMS Regional Office Part II of the Medicaid NCCI Advance Planning Document (APD) and sufficient official state documentation of a conflict with state law, regulation, administrative rule, or payment policy.

If a state subsequently wishes to request CMS approval to deactivate additional Medicaid NCCI edits, it is not required to submit a Medicaid NCCI APD Update. Instead, the state may submit to its CMS Regional Office the following information and documentation:

- a list of the specific new or revised Medicaid PTP edits or MUEs for which CMS approval for deactivation is being requested;
- specification of whether the requested deactivation is for practitioner (PRA), outpatient hospital (OPH), or durable medical equipment (DME) edits;
- the rationale for the requested deactivation; and
- a copy of, or link to, the state law, regulation, administrative rule, or payment policy which conflicts with the new or revised Medicaid PTP edits or MUEs.

States should allow sufficient time for the review of deactivation requests by CMS prior to the scheduled implementation of new and revised Medicaid NCCI edits.

Deactivation of an edit means that the state's MMIS is set so that a specific Medicaid PTP edit or MUE is not applied either to all claims or to claims from a specific type of provider. This is different from making an "individual case exception" on a single Medicaid claim.<sup>26</sup>

## **7.4.3 Reconsideration of Individual Medicaid NCCI Edits for All States**

If a state Medicaid agency believes that a Medicaid PTP edit or MUE should be revised or eliminated for all states, it may request reconsideration of the edit by submitting the request and the rationale for the proposed change, including supporting documentation from the medical literature (if applicable), to Correct Coding Solutions (CCS), LLC, at [Adrian.Oleck@correctcodingsolutions.com](mailto:Adrian.Oleck@correctcodingsolutions.com). If the request is for reconsideration of an MUE, the

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<sup>25</sup> See also section 7.5.4 of this document for requesting CMS approval to deactivate individual PTP edits and section 7.6.2.5 of this document for requesting CMS approval to deactivate individual MUEs.

<sup>26</sup> See section 7.4.1 of this document.

state should propose an alternative value for the MUE. CCS will analyze the request and documentation and make a recommendation to CMS, which will make the final decision.

## **7.5 Procedure-to-Procedure Edits**

### **7.5.1 Scope of Applicable Medicaid Claims Needed for Procedure-to-Procedure Edits**

The column one code and the column two code of a PTP edit are always billed by a provider on different claim lines, but are usually billed within the same claim. However, for situations in which the codes are billed on different claims, a state's MMIS needs to be able to identify all HCPCS / CPT codes billed by the same provider for the same Medicaid beneficiary on the same date of service on all claim lines on all applicable Medicaid claims and apply the Medicaid PTP edits to these codes, when appropriate.

### **7.5.2 Column One Code of a Procedure-to-Procedure Edit**

A state's MMIS should be programmed so that a PTP edit is applied only to codes for which the column one code is eligible for payment. A PTP edit should be bypassed if the column one code of the edit is not eligible for payment.

There is nothing in the Medicaid NCCI claim-adjudication rules about the reason for the denial of the column one code. If the column one code is not eligible for payment, the Medicaid NCCI claim-adjudication rule requires that payment of the column two code not be denied by the Medicaid NCCI edit. However, if a state wants to establish its own state-specific edits to be applied after the Medicaid NCCI PTP edits, it may do so, but any resulting denial of payment should not be characterized as a denial due to the Medicaid NCCI edits.

When the column one code and the column two code of a PTP edit with a Correct Coding Modifier Indicator (CCMI) of "0" are both billed by a provider on one or more Medicaid claims, the column one code will be eligible for payment and payment for the column two code will be denied. For PTP edits with a CCMI of "1", the PTP edit will not be applied if one of the specified NCCI PTP-associated modifiers is added to one of the two codes of the PTP edit.<sup>27</sup> When the two services are provided in separate encounters, both services will be eligible for payment.

### **7.5.3 Procedure-to-Procedure Edits for Immunization Administration and Preventive Medicine Services**

If a Medicaid beneficiary receives one or more immunizations and a "significant, separately identifiable" preventive-medicine evaluation-and-management (E&M) service from the same

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<sup>27</sup> Section 8.1 of this document specifies the NCCI PTP-associated modifiers.

provider on the same date of service, the provider's Medicaid claim(s) should include both the immunization administration code (CPT codes 90460 – 90474) and the comprehensive preventive-medicine E&M code (CPT codes 99381 – 99397) with modifier 25 appended. Modifier 25 will enable the PTP edits for these codes to be bypassed, so that both the immunization administration code and the preventive-medicine E&M code will be reimbursed.

If the same Medicaid beneficiary returns to the provider on another day just to receive another immunization, the provider's Medicaid claim for that visit should just list the immunization administration code. If the provider also bills a comprehensive preventive-medicine E&M code for the same day and does not append modifier 25, the Medicaid PTP edits will deny payment of the preventive-medicine E&M code.

On January 1, 2013, new Procedure-to-Procedure (PTP) edits became effective in the Medicaid National Correct Coding Initiative (NCCI) program that paired the immunization administration codes (CPT codes 90460 – 90474) as column one codes with the preventive medicine E&M service codes (CPT codes 99381 – 99397) as column two codes.<sup>28</sup>

Due to concerns expressed by a number of sources, in February 2013 CMS gave state Medicaid agencies the option to unilaterally deactivate these edits in their Medicaid Management Information Systems (MMISs). CMS has decided that the option for states to unilaterally deactivate these edits will end on March 31, 2014, and will not be renewed.

The effective date for these edits will remain January 1, 2013. States will not be allowed to change this effective date for these edits.

All state Medicaid agencies should implement these edits using the standard PTP claim-adjudication rules. For states that have been deactivating the edits, this means that the PTP edits would be applied to claims with dates of service on or after January 1, 2013, that are processed on or after April 1, 2014.

All of these edits have a Correct Coding Modifier Indicator (CCMI) of “1” and, therefore, the PTP edit will be bypassed if the provider has correctly appended a PTP-associated modifier, e.g., modifier 25, to the preventive medicine E&M code.

If the provider performed a comprehensive preventive medicine evaluation, in addition to the immunization administration, but neglected to add modifier 25 to the E&M code, the provider could be instructed to resubmit the claim with the modifier appended or to submit the denied claim through the state Medicaid program's usual process for handling claim denials.

As with all Medicaid NCCI edits, a state can request through its CMS Regional Office CMS approval to deactivate these edits by providing official state documentation that these edits conflict with state law, regulation, administrative rule, or payment policy.

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<sup>28</sup> These PTP edit code pairs are listed in Appendix 2 of this document.

#### **7.5.4 Procedure for States to Request Centers for Medicare & Medicaid Services Approval to Deactivate Individual Procedure-to-Procedure Edits**

A state should request through its CMS Regional Office CMS approval to deactivate one or more Medicaid PTP edits, if the edit is, or the edits are, in conflict with state law, regulation, administrative rule, or payment policy. Three possible reasons (not all inclusive ) for a conflict are:

- when the state allows separate payment for a service or item that is usually bundled into the payment for the column one code;
- when the state requires prior authorization for payment of both codes of a PTP edit pair; and
- when the state's MMIS is set so that the column two code in a PTP edit will deny payment, even if the column one code is denied payment for other reasons.

When a state requests CMS approval to deactivate a Medicaid PTP edit because the state requires prior authorization for both codes in the edit pair, the state must submit in its request information about the specifics of its prior authorization requirements for the code.

In its request, the state should provide responses to the following questions:

- Is prior authorization required for both codes in all situations or only in certain situations (e.g., specific provider types, specific programs)?
- Are the individual codes that are being prior authorized identified and noted in the beneficiary's record or is the prior authorization only for a general plan of care?
- Is the prior authorization clearly focused on services / items rendered / dispensed on a single DOS rather than sequentially over a span of time?

As stated in the *Medicaid NCCI Edit Design Manual*, NCCI PTP edits should be applied to a code pair only if the column one code is eligible for payment. If it is not, the PTP edit should be bypassed. However, if a state's MMIS is set so that payment for the column two code in a PTP edit will be denied, even if payment for the column one code is denied for other reasons, it is recommended that the state request deactivation of PTP edits in which the column one code is never covered, in order to prevent unintended denial of payment of the column two code. If a state's MMIS is set so that the PTP edit will be bypassed if payment of the column one code is denied for other reasons, it is not necessary to request deactivation of PTP edits in which the column one code is never covered. It is also not necessary to request deactivation of edits in which just the column two code is never covered.

In submitting a request for CMS approval to deactivate one or more Medicaid NCCI edits, a state must submit to its CMS Regional Office sufficient official state documentation of the state law,

regulation, administrative rule, or payment policy that conflicts with the Medicaid PTP edit(s) for the codes identified.

### **7.5.5 State-Specific Procedure-to-Procedure Edits**

A state is allowed to apply to claims state-specific PTP edits which are based on state-specific regulations or payment policies. However, state-specific PTP edits must be applied to claims after Medicaid NCCI PTP edits have been applied.<sup>29</sup> State-specific PTP edits may deny payment for codes on Medicaid claims for which a Medicaid PTP edit was bypassed due to the presence of a PTP-associated modifier. Denials of payment due to state-specific PTP edits must be clearly characterized as state-specific denials of payment, not as NCCI denials of payment.

## **7.6 Units-of-Service Edits and Medically Unlikely Edits**

### **7.6.1 Units-of-Service Edits in General<sup>30</sup>**

A units-of-service (UOS) edit is defined by at least six elements:

- the HCPCS or CPT code or codes covered by the edit (e.g., a single physical therapy code or multiple physical therapy codes);
- the number of claim lines the edit is applied to in each claim (e.g., a single claim line or all claim lines);
- the period of time the edit is applied to (e.g., all claims on the same DOS, all claims with a DOS in a calendar year, or all claims with a DOS in a rolling 12-month period);
- the providers the edit is applied to (e.g., the same provider, one or more categories of providers, or all providers);
- the unit of measure used by the edit (e.g., per procedure [e.g., for a surgical procedure or diagnostic test], per encounter or visit [e.g., for most evaluation-and-management codes]; or per unit of time [e.g., per 15 minutes or per day]); and
- the “value” of the edit, which is the maximum number of UOS allowed by the edit.

The claim-adjudication rule for a UOS edit specifies the number of UOS that will be paid in most circumstances for the HCPCS or CPT code, if the number of UOS billed exceeds the “value” for the UOS edit. For example, the claim-adjudication rule for a state-specific UOS edit

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<sup>29</sup> Refer to Sections 7.3 – 7.3.3 for more information on order of edits.

<sup>30</sup> All units-of-service edits are assumed here to apply to claim lines and claims for the same beneficiary. This includes Medically Unlikely Edits (MUEs).

may allow all UOS up to the “value” of the UOS edit to be paid; UOS billed above that “value” will not be paid.<sup>31</sup>

## 7.6.2 Medically Unlikely Edits

“Medically Unlikely Edits” (MUEs) are UOS edits in CMS’s NCCI. All MUEs are UOS edits, but not all UOS edits are MUEs.

A CMS NCCI MUE is defined by the following elements:

- the HCPCS or CPT code;
- a value;
- an effective date; and
- a deletion date (if applicable).

An MUE is applied to the UOS billed for a HCPCS / CPT code on only one line of a Medicaid claim at a time.

If a Medicaid claim contains the same HCPCS / CPT code and the same date of service on more than one line of the claim, the MUE is applied to each claim line individually. The MUE for that code is not applied to the sum of the UOS across all lines of the claim for the same code and same date of service.

If a provider bills the same HCPCS / CPT code on the same date of service for the same Medicaid beneficiary on more than one Medicaid claim, the MUE for that code is not applied to the sum of the UOS across all of these claims for this code and this date of service.

The claim-adjudication rule required for all MUEs is that payment of all UOS billed on a claim line is denied, if the number of UOS billed for a code on the claim line is greater than the “value” of the MUE for that code.

MUEs are coding edits, not medical necessity edits. They do not define the UOS that are allowable for individual patients. An MUE for a HCPCS / CPT code is the maximum number of UOS allowable under most circumstances for the same beneficiary on the same date of service by the same provider. They allow the vast majority of appropriately coded claims to pass the MUE.

If a provider wants to bill medically reasonable and necessary UOS in excess of the MUE “value”, the provider can bill the same HCPCS / CPT code on two or more lines of a claim by

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<sup>31</sup> This is only an example of a state-specific claim-adjudication rule that a state might adopt for its own state-specific UOS edits. States are not permitted to use this claim-adjudication rule for the Medicaid NCCI Medically Unlikely Edits (MUEs). The claim-adjudication rule required by CMS for the NCCI MUEs is given in the following section.

dividing the UOS among the claim lines. However, some states or contractors may use a duplicate claim-line rule which considers billing the same HCPCS / CPT code on more than one line of a claim without a modifier appended to the HCPCS / CPT code to be duplicates and denies payment of UOS reported on the additional claim line or lines.

To prevent denial of payment of the UOS billed for the same HCPCS / CPT code on more than one claim line as a duplicate, a state can specify one or more HCPCS / CPT modifiers a provider can append to the HCPCS / CPT code to indicate that the UOS billed for the code on that claim line are in addition to the UOS billed for the same code on a different claim line.<sup>32</sup> However, the modifier that is used should not be one of the designated PTP-associated modifiers.<sup>33</sup>

However, appending such a state-specific modifier to the HCPCS / CPT code will not cause the MUE to be bypassed for the code on that claim line. If the number of UOS billed for a code on a line of a Medicaid claim exceeds the MUE value for that code, then payment must be denied for all UOS billed for that code on that claim line. Any denial of payment due to a Medicaid NCCI edit can be appealed through the state's payment appeals process, be reviewed, and be overturned, if the services provided are determined to have been medically necessary.

MUEs vary in their "value" and in the unit of measure used. The "value" of all MUEs for all HCPCS / CPT codes for which the unit of measure is "per diem" is "1".

If the unit of measure for a HCPCS / CPT code is not "per diem", e.g., "per 15 minutes", and the MUE value for that code is, e.g., "2", then the maximum number of UOS that should be paid in most circumstances for that HCPCS / CPT code billed on one line of a Medicaid claim is "2". If the number of UOS billed for that code on that one claim line is greater than "2", then none of the UOS billed for that code on that claim line should be paid.

#### **7.6.2.1 Medically Unlikely Edits and Span Dates**

If a state allows a provider to bill UOS for a HCPCS / CPT code on one line of a Medicaid claim that cover more than one day (e.g., one month) and directs the provider to use "span dates" on the claim line (i.e., the "To" date is different from the "From" date), then to determine whether the billed UOS pass the MUE, the state must divide the number of UOS billed for the code on one line of a Medicaid claim by the number of days between the "From" date and the "To" date (i.e., the "date span") and round the quotient to the nearest whole number before applying the MUE value for that code.

For example, the provider bills a HCPCS / CPT code which has an MUE value of "1". The "From" date listed on the claim line is 07/01/2013 and the "To" date is 07/10/2013. The "date span" of the claim line is 10 days. If the UOS billed on the claim line are "14", those UOS should be divided by the number of days in the date span (10) to determine the number of UOS

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<sup>32</sup> HCPCS / CPT modifier "GD" is one example of a modifier that a state can specify for providers to use to bypass a state edit to detect and void what may appear to the MMIS to be a duplicate claim line, but is not.

<sup>33</sup> Listed in section 8.0 of this document.

billed “per day”. In this example, the “per day” UOS equal “1.4”. Rounding to the nearest whole number would make the “per day” UOS equal “1”. The value of “1” would pass the MUE edit and all 14 UOS billed on the claim line would be paid.

However, a claim line with a date span of 10 days that billed 15 UOS on the claim line would calculate to “1.5” UOS per day and would be rounded to “2” UOS per day. This value would exceed the MUE value of “1” for the code and payment for all 15 UOS on the claim line should be denied.

### **7.6.2.2 Medically Unlikely Edit for Immunization Administration (CPT Code 90472)**

CPT codes 90460 – 90472 for the administration of immunization vaccines and toxoids by injection are billed in conjunction with CPT codes 90476 – 90749 for the vaccines / toxoids themselves.

90471 is the CPT code for the administration of the first vaccine / toxoid. The MUE value for this code is “1”.

90472 is the CPT code for the administration of each additional vaccine / toxoid (either single or combination). The Medicaid MUE value for this code is “5”.

Billing CPT code 90472 always requires billing CPT code 90471. Consequently:

- the maximum UOS allowed by the combination of MUE values for these two CPT codes is “6” and
- payment will be denied only if the number of vaccine / toxoid injections given to the same beneficiary on the same day is seven or more.

If seven or more immunization injections for the same beneficiary on the same day are medically justified, then the provider can bill the injections with code 90472 on two lines of a Medicaid claim or can appeal denial of payment through the state’s appeals process.

Alternatively, a state Medicaid agency can request through its CMS Regional Office CMS approval to deactivate the Medicaid MUE for code 90472, if state policy allows more than six immunization injections for the same beneficiary on the same day and if the state submits sufficient official state documentation of the conflict with state law, regulation, administrative rule, or payment policy.

### **7.6.2.3 Medically Unlikely Edits for Bilateral Procedures and Items**

For surgical procedures for which the code describes a unilateral procedure that can also be performed bilaterally, the MUE value is generally set as “1”. However, if the same procedure

can be performed at more than one site on the same side of the body, the MUE value may be higher.

The preferred way for providers to bill a surgical procedure that is performed at a single site on each side of the body is to bill the code on a single claim line with modifier 50 appended to the code and one UOS. This is the billing requirement specified by the Medicare program and serves as the basis for many MUEs. Use of modifier 50 allows the state to reimburse more for a bilateral procedure than it does for a unilateral procedure.

Alternatively, the state can instruct providers to bill a bilateral surgical procedure on two claim lines (e.g., one with the RT modifier and one UOS and the other with the LT modifier and one UOS), but this is not the recommended approach.

For radiologic procedures, other non-surgical diagnostic procedures, and durable medical equipment that can be performed or used bilaterally, the MUE value is generally set as “2” to permit the billing of bilateral procedures / items on a single claim line with two UOS. As with surgical procedures, states have the option to instruct providers to report bilateral procedures / items on separate claim lines.

MUEs should not be bypassed by the modifiers that are appended to codes to indicate bilateral procedures.

#### 7.6.2.4 Medically Unlikely Edits with a Value of “0”

MUEs *may have a value of “0” for various reasons – for example:* :

- *The outpatient hospital (OPH) MUE may be “0” for a surgical or non-surgical therapeutic procedure code(s) that Medicare has determined would not be performed in an outpatient setting. The corresponding practitioner (PRA) MUE will not be “0”.*
- *The OPH MUE may be “0” for an evaluation-and-management code that specifies an inpatient hospital service. The corresponding PRA MUE will not be “0”.*
- *The MUE for a drug may be “0” if it is no longer being manufactured.*
- *The MUEs are “0” for compounded nebulizer drugs based on Medicare Policy.*
- *The DME MUE for an injectable drug may be “0” if Medicare has determined that it should not be administered in the home setting.*

*For situations in which the Medicaid MUE is “0” based on Medicare policy, CMS has determined that it is equally appropriate as NCCI policy for Medicaid.*

If payment for a HCPCS / CPT code on Medicaid claim is denied because the Medicaid MUE value for the code is “0”, the state should use a denial message that indicates that the claim line was denied because of an MUE.

States may make “individual case exceptions” to an MUE denial, if they determine that the service is correctly coded and is medically necessary, which would include whether it was performed in an appropriate setting.<sup>34</sup>

#### **7.6.2.5 Procedure for States to Request Centers for Medicare & Medicaid Services Approval to Deactivate Individual Medically Unlikely Edits**

A state should request through its CMS Regional Office CMS approval to deactivate one or more Medicaid MUEs, if the MUE is, or the MUEs are, in conflict with state law, regulation, administrative rule, or payment policy. Three of the most common reasons for a conflict are the following:

- when the unit of measure that a state directs providers to use for a HCPCS / CPT code in filing a Medicaid claim is different from the unit of measure that was used to set the MUE value for that code, e.g., when the unit of measure for establishing an MUE for a particular code is “per visit or encounter” and the state directs providers to bill that code on Medicaid claims with a unit of measure of “15-minute” increments;
- when the state requires prior (service) authorization for Medicaid payment of a code and the prior authorization process includes a determination of the allowable number of UOS to be provided to, and paid for, the Medicaid beneficiary; and
- when the state has a published policy that allows more UOS per day than the MUE value.

A state policy that allows a higher number of UOS per year is not likely to be in conflict with an MUE that allows one UOS per day.

When a state requests CMS approval to deactivate the Medicaid MUE for a code because the state requires prior authorization for provision and payment of the code in its Medicaid program, the state must submit in its request information about the specifics of its prior authorization requirements for the code.

In its request, the state should provide responses to the following questions:

- Is prior authorization required for the code in all situations or only in certain situations (e.g., specific provider types, specific programs, or only if the UOS exceed a specific value)?
- Is the individual code that is being prior authorized identified and noted in the beneficiary’s record or is the prior authorization only for a general plan of care?

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<sup>34</sup> See section 7.4.1.

- Is the specific number of UOS prior authorized noted in the beneficiary's record and enforced at the time of claim adjudication?
- Is the prior authorization for services / items rendered / dispensed on a single DOS or over a span of time?

Prior authorization of multiple UOS for a code over a span of time would usually not justify the deactivation of a Medicaid MUE for the code, which only looks at the number of UOS on a single DOS.

In submitting a request for CMS approval to deactivate one or more Medicaid NCCI edits, a state must submit to its CMS Regional Office sufficient official state documentation of the state law, regulation, administrative rule, or payment policy that conflicts with the Medicaid MUE(s) for the code(s) identified.

### **7.6.3 State-Specific Units-of-Service Edits**

If a previously existing state or contractor Medicaid edit is identical to a Medicaid NCCI edit (i.e., same beneficiary, same provider, and same date of service), the edit is now considered to be a Medicaid NCCI edit, not a state or contractor edit. Any savings in Medicaid program costs achieved as a result of such an edit should be attributed to the use of the Medicaid NCCI methodologies. State or contractor edits that exactly duplicate Medicaid NCCI edits can either be deactivated or be applied after the Medicaid NCCI edits are applied to a Medicaid claim.

If the value of a state UOS edit for a particular HCPCS / CPT code that defines the elements the same as an MUE does (i.e., same beneficiary, same provider, and same date of service) is less than the MUE value for that code, the state must apply the lower value of its state-specific UOS edit after the MUE has been applied to the claim line. If the UOS billed on the claim line exceed the value of the MUE, payment of all UOS for this code on the claim line should be denied by the MUE and reported to the provider as a denial due to a Medicaid NCCI edit.

If the UOS billed for a code on a claim line are less than or equal to the MUE value for the code, but are higher than the value of the state-specific UOS edit for the code, the state may deny payment of some or all of the UOS billed on the claim line for the code.

Prior CMS approval is not needed for a state to do this. However, the denial of payment for UOS that exceed the value of the state-specific UOS edit should not be attributed to the Medicaid NCCI program and should not be reported to the provider as a denial of payment due to a Medicaid NCCI edit because it was a state UOS edit that denied the payment, not an MUE.

If a state or contractor Medicaid edit conflicts with a Medicaid NCCI edit, a state is to use the Medicaid NCCI edit, and not the state / contractor edit, unless the state receives CMS approval to deactivate the Medicaid NCCI edit.

## **7.7 CLEIDS and Medically Unlikely Edit Rationales**

Each NCCI PTP edit and MUE has a corresponding “Correspondence Language Example Identification Number” (CLEID). The CLEID provides information to state Medicaid agencies and fiscal agents about the rationale for these edits that can be used by states to help educate providers about the edits. For example, a state may refer to the CLEID when responding to an inquiry about a specific Medicaid NCCI PTP edit or MUE or to an appeal of a claim line that was denied due to a Medicaid NCCI edit.

The CLEID that corresponds to each Medicaid NCCI edit is included in the quarterly Medicaid NCCI edit files that are posted on the MII website on the RISSNET portal. The CLEIDs are not included in the quarterly Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website. Detailed information about CLEIDs is found in the *NCCI Correspondence Language Manual for Medicaid Services* that is posted on the MII website and on the Medicaid NCCI webpage of the Medicaid.gov website.

In addition, for each Medicaid MUE, the quarterly Medicaid NCCI edit files that are posted on the Medicaid NCCI webpage on the Medicaid.gov website contain the rationale for each Medicaid MUE, which provides more detail than the CLEIDs. These MUE rationales are not yet included in the files that are posted on the MII website on the RISSNET portal.

## **7.8 Add-On Code Edits**

An add-on code is a HCPCS / CPT code that describes a service that is always performed and reported in conjunction with another primary service. The add-on code is eligible for payment if, and only if, it is reported with an appropriate primary code that is performed by the same practitioner for the same beneficiary on the same DOS and that is paid. An add-on code edit would deny an add-on code, if the related primary code is not reported by the same provider for the same beneficiary on the same DOS or is reported, but not paid.

Add-on code edits are now part of the Medicare NCCI program, but are optional for state Medicaid agencies to use. If a state Medicaid agency chooses to implement add-on code edits, these edits and any resulting denials should be characterized as state-specific edits / denials; they should not be characterized as NCCI edits / denials and should not be included in the state’s quarterly reports to CMS of estimated savings in Medicaid program costs due to use of the Medicaid NCCI methodologies.

## **8.0 Modifiers**

CMS requires that every state incorporate into its MMIS all modifiers for HCPCS codes and CPT codes needed for the correct adjudication of applicable Medicaid claims.

## 8.1 Modifiers Associated with Procedure-to-Procedure Edits

PTP claim-adjudication rules identify specific PTP-associated modifiers which are needed to bypass PTP edits which have a CCMI of “1”. PTP-associated modifiers may be appended, if, and only if, appropriate, based on clinical circumstances and in accordance with the NCCI program and HCPCS / CPT Manual instructions / definitions for the modifier / procedure code combination.

When a provider correctly appends one of these modifiers to a HCPCS / CPT code that is one of the codes in a PTP edit with a CCMI of “1”, the PTP edit must be bypassed. PTP-associated modifiers are 24, 25, 27, 57, 58, 59, 78, 79, 91, E1 – E4, F1 – F9, FA, LC, LD, LM, LT, RC, RI, RT, T1 – T9, TA, XE, XP, XS, and XU. (Modifiers XE, XP, XS, and XU are valid for claims with dates of service on or after January 1, 2015.)

A separate and distinct E&M service is billed with modifier 24, 25, or 57<sup>35</sup>. Modifiers 24, 25, and 57 should only be appended to an E&M code (99201 – 99499, 92002-92014), regardless of whether the E&M code is the column 1 or column 2 code. They should never be appended to other types of codes, such as surgery codes.

When a provider appends modifier 25 to a comprehensive preventive-medicine E&M code (CPT codes 99381 – 99397) and also bills an immunization administration code (CPT codes 90460 – 90474) for the same Medicaid beneficiary on the same date of service, a state’s MMIS must allow modifier 25 to bypass the PTP edits for these codes, so that both the immunization administration and preventive-medicine E&M codes will be paid.

A paper on the proper use of modifier 59 is contained on the Medicaid NCCI webpage on the Medicaid.gov website ([http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/NCCI\\_MODIFIER\\_59pdf.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/NCCI_MODIFIER_59pdf.pdf)). Additional information about modifier 59 is found in Section E of Chapter 1 of the *NCCI Policy Manual for Medicaid Services*.

The anatomical PTP-associated modifiers are E1 – E4, F1 – F9, FA, LC, LD, LM, LT, RC, RI, RT, T1 – T9, and TA. A state’s MMIS should be programmed so that, if a PTP edit has a CCMI of 1, if both codes have the same anatomical modifier, and if neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, then the PTP edit should not be bypassed and payment of the column two code should be denied. For example, if both codes have modifier RT as the only modifier, the PTP edit should not be bypassed and payment of the column two code should be denied. However, if both codes have modifier RT and one of the codes also has modifier 59, a PTP edit with a CCMI of 1 should be bypassed.

## 8.2 Modifiers Associated with Medically Unlikely Edits

The preferred way for providers to bill a surgical procedure that is performed at a single site on each side of the body is to bill the code on a single claim line with modifier 50 appended to the

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<sup>35</sup> Modifiers 24 and 57 are used with E&M codes only when the related code is a surgery service.

code and one UOS. Modifier 50 is needed for a MMIS to correctly adjudicate the MUE for a surgical procedure code billed on a line of a Medicaid claim, when the procedure has been performed bilaterally and the state Medicaid agency instructs providers to bill a surgical procedure that is performed at a single site on each side of the body on a single claim line with modifier 50 appended to the code

Use of modifier 50 allows the state to reimburse more for a bilateral procedure than it does for a unilateral procedure. The use of modifier 50 to identify a bilateral surgical procedure should not result in the MUE being bypassed.

The only modifier that has a direct impact on the adjudication of Medicaid claims with MUEs is modifier 55.<sup>36</sup> If a state pays a global fee for surgical procedure codes and allows splitting of the fee for postoperative management by a different practitioner, the state's MMIS should allow the Medicaid MUEs for these codes to be bypassed on a line of a Medicaid claim, if modifier 55 is appropriately attached to the code that is billed.

### **8.3 State-Specific Modifiers and Modifier Edits**

The Medicaid NCCI program does not require state Medicaid programs to implement their own edits that address the appropriate use of modifiers. However, states are free to implement their own edits that address this issue. If a state does implement its own edits related to the appropriate use of modifiers, the edits must be characterized as state edits, not as NCCI edits.

States may implement edits that deny or reject claim lines in which a modifier is inappropriately appended to a HCPCS / CPT code (e.g., use of modifier 24, 25, or 57 with a non-E&M code). However, if they do, those edits must be applied to claims prior to the application of NCCI edits and any resulting denials or rejections must be characterized as being due to state-specific edits, not NCCI edits, and they should not be reported as NCCI savings.

If a provider wants to bill medically reasonable and necessary UOS in excess of the MUE "value", the provider can bill the same HCPCS / CPT code on two or more lines of a claim by dividing the UOS among the claim lines. However, some states or contractors may use a duplicate claim-line logic which considers billing the same HCPCS / CPT code on more than one line of a claim without a modifier appended to the HCPCS / CPT code to be duplicates and denies payment of UOS reported on the additional claim line or lines.

To prevent denial of payment of the UOS billed for the same HCPCS / CPT code on more than one claim line as a duplicate, a state can specify one or more HCPCS / CPT modifiers (other than a PTP-associated modifier) that a provider can append to the HCPCS / CPT code to indicate that the UOS billed for the code on that claim line are in addition to the UOS billed for the same code on a different claim line.

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<sup>36</sup> This differs from the claim-adjudication rules for NCCI PTP edits. These rules direct that the PTP edit be bypassed, if the Correct Coding Modifier Indicator (CCMI) for the edit is "1" and if one of the 40 specified PTP-associated modifiers is appropriately appended by the provider to one of the codes billed in the pair of HCPCS / CPT codes for the PTP edit.

HCPCS / CPT modifier “GD” is one example of a modifier that a state can specify for providers to use to bypass a state edit to detect and void what may appear to the MMIS to be duplicate claim line, but is not. However, appending such a state-specific modifier to the HCPCS / CPT code should not cause the MUE to be bypassed for the code on that claim line.

## **Appendix 1: List of Acronyms**

ACA: Affordable Care Act

APD: Advance Planning Document

ASC: Ambulatory Surgery Center

CCMI: Correct Coding Modifier Indicator

CLEID: Correspondence Language Example Identification Number

CMCS: Center for Medicaid and CHIP Services

CMHC: Comprehensive Mental Health Center

CMS: Centers for Medicare & Medicaid Services

COTS: Commercial Off-The-Shelf

CPT: Current Procedural Terminology

DME: Durable Medical Equipment

DOS: Date of Service

E&M: Evaluation and Management

FFP: Federal Financial Participation

FFS: Fee-For-Service

FQHC: Federally Qualified Health Center

HCPCS: Healthcare Common Procedure Coding System

MCO: Managed Care Organization

MII: Medicaid Integrity Institute

MMIS: Medicaid Management Information System

MUE: Medically Unlikely Edit

NCCI: National Correct Coding Initiative

NDC: National Drug Code

NMEH: National Medicaid Electronic Data Interchange Healthcare

NPI: National Provider Identifier

OPH: Outpatient Hospital

PCCM: Primary Care Case Management

PRA: Practitioner

PTP: Procedure-to-Procedure

RHC: Rural Health Clinic

SSA: Social Security Act

UOS: Units of Service

**Appendix 2: Medicaid Procedure-to-Procedure Edits for Immunization Administration and Preventive Medicine Services<sup>37</sup>**

COL1	COL2
90460	99381
90460	99382
90460	99383
90460	99384
90460	99385
90460	99386
90460	99387
90460	99391
90460	99392
90460	99393
90460	99394
90460	99395
90460	99396
90460	99397
90461	99381
90461	99382
90461	99383
90461	99384
90461	99385
90461	99386
90461	99387
90461	99391
90461	99392
90461	99393
90461	99394
90461	99395
90461	99396
90461	99397

COL1	COL2
90471	99381
90471	99382
90471	99383
90471	99384
90471	99385
90471	99386
90471	99387
90471	99391
90471	99392
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90472	99392
90472	99393
90472	99394
90472	99395
90472	99396
90472	99397

COL1	COL2
90473	99381
90473	99382
90473	99383
90473	99384
90473	99385
90473	99386
90473	99387
90473	99391
90473	99392
90473	99393
90473	99394
90473	99395
90473	99396
90473	99397
90474	99381
90474	99382
90474	99383
90474	99384
90474	99385
90474	99386
90474	99387
90474	99391
90474	99392
90474	99393
90474	99394
90474	99395
90474	99396
90474	99397

<sup>37</sup> See section 7.4.3 of this document.