MEDICAID NCCI
(MCDNCCI)

MCDNCCI File Names and Formats, Algorithms
For Processing Claims, and Characteristics of Edits

The document contains separate information for NCCI procedure-to-procedure edits and MUE units-of-service edits.

NCCI Procedure-to-Procedure Code Edits (File Names)
There will be two separate NCCI procedure-to-procedure code edit files:

(1) Practitioner/ASC NCCI Edit Table: "**MCD-PR-vXX.X**"
(2) Outpatient Hospital NCCI Edit Table: "**MCD-HOS-vXX.X**".

Note: vXX.X refers to the version number. The first MCDNCCI version for October 1, 2010, will be labeled v 1.3.1.

Characteristics of each NCCI procedure-to-procedure edit:

(1) NCCI edits apply to services by same provider to same beneficiary on same date of service.
(2) Each edit consists of a code pair (column one code and column two code), policy statement, the CLEID, an effective date, a deletion date if applicable, and a modifier indicator.
    (a) Column one HCPCS/CPT code
    (b) Column two HCPCS/CPT code
    (c) Policy statement – The coding rationale for the edit
    (d) CLEID – Correspondence Language Example Identification number for correspondence – See Attachment F for information about how the CLEID is utilized.
    (e) Effective date – The date that an edit was initially implemented. Claims with dates of service "on or after" this date and "on or before" the deletion date (if any) must be subject to the edit.
    (f) Deletion date – The last date that an edit is active. Claims with dates of service "on or before" the "deletion date" and "on or after" the "effective date" must be subject to the edit. Claims with dates of service after the deletion date are not subject to the edit.
    (g) Modifier indicator
        (i) "0" – Edit cannot be bypassed with an NCCI-associated modifier. The column one code passes the edit (i.e. eligible for payment) but the column two code should be denied (i.e. not paid) even if an NCCI-associated modifier is appended to one of the codes of the edit pair. (See information below about NCCI-associated modifiers below.)
        (ii) "1" – Edit may be bypassed if an NCCI-associated modifier is appropriately appended to one or both codes of an edit pair. If an NCCI-associated modifier is appropriately appended to one or both codes of an edit pair, both the

column one and column two codes are eligible for payment. (See information below about NCCI-associated modifiers.)

(iii) "9" – The edit was deleted retroactive to its implementation date. The edit pair is not active and should not be the basis for denying either code of the edit.

NCCI-associated modifiers:
Modifiers 25, 27, 58, 59, 78, 79, 91, LT, RT, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, RC, TA, T1, T2, T3, T4, T5, T6, T7, T8, and T9 are modifiers that providers may append to the column one or column two codes of a code pair edit. If an NCCI edit has a modifier indicator of "1", both the column one and column two codes are eligible for payment if one of these modifiers is appended to either code of the code pair edit.

Claim adjudication algorithm for NCCI procedure-to-procedure edits:

(1) Apply edits to services by same provider to same beneficiary on same date of service.

(2) Determine whether type of claim and site of service if applicable are subject to NCCI edits.
   (a) For practitioner claims regardless of site of service, use Practitioner NCCI edit table.
   (b) For ambulatory surgical center claims, use Practitioner NCCI edit table.
   (c) For outpatient hospital claims, use Outpatient Hospital Services NCCI edit table.
   (d) For facility (hospital) emergency department, observation, hospital laboratory services, and all facility therapy services claims, use Outpatient Hospital Services NCCI edit table.

(3) For each HCPCS/CPT code submitted on a claim identify all other HCPCS/CPT codes submitted on current claim or earlier claims in history with the same date of service for the same provider and same beneficiary. This is the subset of HCPCS/CPT codes for each code that needs to be tested against the NCCI procedure-to-procedure edit tables.
   (a) For each code in the subset, use it as a column one code and pair it with every other code in the subset as a column two code. Each code is paired with every other code as both column one and column two codes. (Note that this method identifies code pairs such that each code as a column one code is paired with every other code as a column two code AND each code as a column two code is paired with every other code as a column one code.) Determine whether any of these code pairs match any of the code pair edits in the appropriate NCCI edit table for the relevant type of claim.
   (b) After code pairs that match NCCI edits in the edit table are identified, test date of service against the effective date and deletion date (if relevant) for each edit. Apply NCCI edit to claim only if the date of service is "on or after" the effective date and "on or before" the deletion date of the edit. Most edits do not have deletion dates.

(c) After code pairs that match NCCI edits in edit table with dates of service within the effective period of the corresponding edit are identified, determine whether an NCCI-associated modifier is appended to either or both of the codes of the code pair edit. Proceed as follows:

(i) If modifier indicator of edit is "0", the column two code is denied (not payable) regardless of whether an NCCI-associated modifier is appended. The column one code is eligible for payment.

(ii) If modifier indicator of edit is "1", the column two code is eligible for payment only if an NCCI-associated modifier is appended to either code of the edit pair. That is, the edit is bypassed and both the column one and column two codes are eligible for payment.

(iii) **Note:** If the modifier indicator is "1", Medicaid allows modifier 59 on either the column one or column two code.

(iv) If the modifier indicator of the edit is "9", both codes are eligible for payment. The corresponding edit is inactive and was deleted retroactive to its implementation date.

(d) If a code is denied because of an NCCI edit, a denial message should be added to the code denial on the provider payment notice and the beneficiary notice (explanation of benefits) if one is provided by the State program. Some recommendations follow:

(i) Provider Payment Notice Advice alternatives:

i. "Payment denied based on NCCI edit"

ii. "Payment denied because service not payable with another service on the same date of service."

iii. Do NOT state:

a. "Payment denied because service is component of another service (or integral to another service) on same date of service." Most NCCI edits are NOT based on one service being a component of another more comprehensive service or one service being integral to another service.

(ii) Beneficiary Explanation of Benefits Notice alternatives:

i. "Payment denied since payment included in another service billed."

(e) There should also be a notice on the claim payment advice indicating that denied service SHOULD NOT be billed to the beneficiary. The denied service is a provider liability. Provider cannot use an "Advanced Beneficiary Notice" or waiver of liability to obtain payment from beneficiary.

(4) The Provider Payment Notice Advice should state that a code denial due to an NCCI edit may be appealed. See Attachment E for adjudication rules for appeals of a denied service due to an NCCI edit.

(5) Because reported HCPCS/CPT codes for the same date of service on the current claim are tested with all other codes with the same date of service from claims in history, it is possible that an NCCI edit will be triggered where the column two code that should be denied was previously paid from a claim in history that was adjudicated earlier. If this occurs, the claims processing contractor must perform a **payment adjustment** from the prior claim where the column two code was previously paid. That is, the claims processing contractor must adjust payment on the current claim to reflect the fact that a code was paid on a prior claim in history that hit an NCCI edit and in retrospect based on the new information on the current claim should not have been paid.

NCCI Procedure-to-Procedure Edit File Format:

(1) When the NCCI procedure-to-procedure edit tables in ASCII.TXT are downloaded from CMS, each edit will have the following format:

a. AAAAABBBBBCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCDD.EEEEEEEE EyyyydddyyyydddI

Field Name	Notes	Type	Beg. Char	# of Char
Col 1 code	AAAAA	alpha-numeric text	1	5
Col 2 code	BBBBB	alpha-numeric text	6	5
Policy Statement	CCCCCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCC	alpha-numeric text	11	60
CLE ID	Correspondence Language Example Identification Number format: DD.EEEEEEEEE The last four characters of the CLEID field may contain empty spaces.	alpha-numeric text	71	12
Effective Date	Julian date format: yyyyddd	Numeric	83	7
Deletion Date	Julian date format: yyyyddd	Numeric	90	7
Correct Coding Modifier Indicator	Indicated above as “I” Valid values = 0, 1, or 9 0 = NCCI modifiers not allowed 1 = NCCI modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric	97	1

MUE (Medically Unlikely Edits) Units-of-Service Edits (File Names)

There will be three separate MUE tables:

(1) Practitioner MUE Table named "**MCD-PR-MUE-vXX.X**". There is one edit table that applies to:
    (a) Practitioner services regardless of site of service AND
    (b) Ambulatory surgical center (ASC) services.
(2) Outpatient Hospital MUE Table named "**MCD-HOS-MUE-vXX.X**". There is one edit table that applies to:
    (a) Outpatient hospital services including critical access hospitals
    (b) Facility (hospital) emergency department services
    (c) Facility (hospital) observation services
    (d) Hospital outpatient laboratory services
(3) Durable Medical Equipment (DME) Table named "**MCD-DME-MUE-vXX.X**". There is one edit table that applies to:
    (a) DME billed by suppliers
    (b) Does NOT apply to DME billed by practitioners. The MUE table for practitioners contains MUEs for DME billed by a practitioner.
    (c) Does NOT apply to DME billed by hospitals. The MUE table for outpatient hospital services contains MUEs for DME billed by a hospital.

Characteristics of each MUE units-of-service edit:

(1) An MUE is a unit of service (UOS) edit for each HCPCS/CPT code that applies to services performed by the same provider/supplier for the same beneficiary on the same date of service.
(2) An MUE is a claim line edit, ***NOT*** an entire claim edit. That is, the MUE is applied separately to the UOS reported on each line of a claim. It is NOT applied to the sum total UOS for a code on the entire claim.
(3) An MUE is NOT a date of service edit. It is not applied to the sum of all UOS for a code with the same date of service. It is a claim line edit.
(4) Each edit consists of a HCPCS/CPT code, an MUE value, an effective date, a deletion date, CLEID, and publication indicator.
    (a) HCPCS/CPT code
    (b) The MUE value for that HCPCS/CPT code.
    (c) Effective date – The date that each edit was first implemented. Claims with dates of service "on or after" this date and "on or before" the deletion date, if any, must be subject to the edit.
    (d) Deletion date – The last date that an edit is active. Claims with dates of service "on or before" this date and "on or after" the effective date are subject to the edit. Claims with dates of service after the deletion date are not subject to the edit.
    (e) CLEID – Correspondence Language Example Identification number for correspondence – See Attachment G for information about how this information is utilized.
    (f) Publication Indicator – This indicator enables a contractor to determine whether an MUE value is published on the CMS Medicare MUE website. If the value is **NOT** published on the CMS website, it is a confidential MUE value and should **NOT** be shared/released to anyone other than CMS or CMS contractors with a valid need for the MUE value.

Claim adjudication algorithm for MUE units-of-service edits:

(1) Apply edits to services by same provider/supplier for same beneficiary on same date of service.

(2) Determine whether type of claim and site of service are subject to MUE edits.
   (a) For practitioner claims regardless of site of service including DME billed by practitioner, use Practitioner MUE Table.
   (b) For ambulatory surgical center claims, use Practitioner MUE Table.
   (c) For outpatient hospital (including critical access hospitals) claims including DME billed by hospital, use Outpatient Hospital MUE Table.
   (d) For hospital facility (including critical access hospitals) emergency department claims, use Outpatient Hospital MUE Table.
   (e) For hospital facility (including critical access hospitals) observation care claims, use Outpatient Hospital MUE Table.
   (f) For DME billed by suppliers, not practitioners or hospitals, use Durable Medical Equipment (DME)) MUE Table.

(3) MUE is a claim line edit that compares UOS (unit of service) reported for the HCPCS/CPT code on the claim line to the MUE value for that code.

(4) If MUE value for HCPCS/CPT code on claim line is greater than or equal to reported UOS on the claim line, the UOS pass the MUE.

(5) If MUE value for HCPCS/CPT code is less than the reported UOS on the claim line, the UOS fail the MUE, and the entire claim line is denied. That is, no UOS are paid for the code reported on that claim line.

(6) Statements (3) – (5) apply to claim lines where the "from date" and the "to date" on the claim are the same. However, if a code subject to an MUE is reported with a different "from date" and "to date" on the claim line, the claims processing contractor should divide the reported units of service on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line, and the rules stated in (4) and (5) above are applied substituting this calculated number for the UOS.

(7) If a claim line is denied (not paid) because of an MUE edit, a denial message should be added to the code denial on the provider/supplier payment notice and the beneficiary explanation of benefits notice. Some recommendations follow:
   (a) Provider/Supplier Payment Notice Advice alternatives:
      (i) "Units of service exceed limit."
      (ii) "Units of service exceed medically unlikely edit."
   (b) Beneficiary Explanation of Benefits Notice Advice alternatives:
      (i) "Payment denied because number of reported services exceeds established limit."
      (ii) "Payment denied because provider billed units of service exceeding limit."

(7) There should also be a notice on the provider/supplier claim payment advice indicating that denied service SHOULD NOT be billed to the beneficiary. Provider/supplier cannot use an "Advanced Beneficiary Notice" or waiver of liability to obtain payment from beneficiary.

(8) Depending upon the procedures of the Fiscal Agent, there should be a notice to provider indicating that provider/supplier may
   (a) Resubmit claim with fewer units of service; or
   (b) Provider may appeal denial of some or all UOS

(9) **Caution:** Since MUE is a claim line edit, not an entire claim edit, the claims processing contractor should **NOT** sum all units of service for a HCPCS/CPT code on the claim or for the same date of service from prior claims in history and compare this number to the MUE value.

(10) **Caution:** A provider/supplier may report the same HCPCS/CPT code on more than one claim line appending a modifier to the code on the second and additional claim lines. The MUE value for the HCPCS/CPT code should be applied separately to the UOS reported on each claim line.

(11) **Caution:** Claims processing contractors may consider developing duplicate claim line logic to prevent providers/suppliers from misusing modifiers to report the same code on more than two lines of a claim. Caution is necessary when developing this type of duplicate logic.

(12) **Caution:** MUEs should **NOT** apply to any code reported with modifier 55.

(13) **Caution:** Modifier 50 is a bilateral modifier indicating that the procedure was performed bilaterally. If the claims processing contractor does not recognize this modifier for payment adjustment purposes, providers should be told to report the code on two lines of a claim utilizing modifier LT on one claim line with one unit of service and modifier RT on one claim line also with one unit of service. The MUE value will be adjudicated separately against the UOS reported on each claim line.

MUE Units-of-Service Edit File Format:

(1) When the MUE units-of-service edit tables are downloaded by the claims processing contractors as ASCII.TXT files, each edit will have the following format:

AAAAANNNNNDD.EEEEEEEEEyyyydddyyyydddP

Field Name	Notes	Type	Beg. Char.	# of Char.
HCPCS/CPT Code	AAAAA	alpha-numeric text	1	5
Maximum Units Allowed	NNNNN formatted with leading zeros (e.g., an MUE of 11 will be written as 00011)	numeric	6	5
CLE ID	Correspondence Language Example Identification Number format: DD.EEEEEEEEE The last four characters of the CLEID field may contain empty spaces.	alpha-numeric text	11	12
Effective Date	Julian date format: yyyyddd	Numeric	23	7

Deletion Date	Julian date format: yyyyddd	Numeric	30	7
Publication Indicator	P Valid values = 0 or 1 0 = not published – confidential - do not share – for use by CMS and CMS contractors ONLY 1 = published - ok to share	Numeric	37	1