MEDICAID NATIONAL CORRECT CODING INITIATIVE

TECHNICAL GUIDANCE MANUAL

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TECHNICAL GUIDANCE MANUAL

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 provides:

- Basic information on the Centers for Medicare & Medicaid Services (CMS) NCCI in the Medicaid program.
- Reference documents on the Medicaid NCCI program.
- Medicaid NCCI edit files and change-report files for the current calendar quarter for the general public and other interested parties.

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

- The NCCI 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 NCCI Technical Guidance Manual (TGM) provides information for state Medicaid agencies and fiscal agents about NCCI policies. It also includes the information that was previously published in the Medicaid NCCI Edit Design Manual which 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 NCCI 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 are provided on the secure RISSNET (Regional Information Sharing Systems) portal. This website is not accessible by the general public. A RISSNET user logs into the secure portal, and under the Resources menu selects Investigative and then selects MII. NCCI information and edit files are in the MII section, under Folders, in the Medicaid NCCI Methodologies subfolder.

2.0 Requirements for State Implementation of the NCCI Methodologies

Section 6507 of the Affordable Care Act (ACA) requires CMS to notify the states to use compatible NCCI methodologies in paying applicable Medicaid claims. The Center for Medicaid and CHIP Services (CMCS) requires that each state completely and correctly implement compatible NCCI methodologies in their Medicaid Enterprise Systems (MES). The MES was formerly known as the Medicaid Management Information System (MMIS).

- All 6 national Medicaid NCCI methodologies unchanged[1]
- All 4 components of each Medicaid NCCI methodology[2]
- The most recent quarterly Medicaid NCCI edit files for states[3]
- The Medicaid NCCI edits in effect for the date of service (DOS) on the claim line or claim
- The claim-adjudication rules in the Medicaid NCCI methodologies[4]
- 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[5]

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 Medicaid Waiver and non-Waiver state Medicaid programs. Medicaid PTP edits and MUEs are designed to address the vast majority of Medicaid claim submissions. Therefore, a state can request CMS' approval to deactivate individual Medicaid NCCI edits which conflict with state law, regulation, administrative rule, or payment policy.[6]

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]

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 manual. States are not permitted to make unilateral decisions on the application of Medicaid NCCI edits.

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[1] The six Medicaid NCCI methodologies are (1) a methodology with PTP edits for practitioner (PRA) 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 (DME); (4) a methodology with MUEs for PRA and ASC services; (5) a methodology with MUEs for outpatient services in hospitals; and (6) a methodology with MUEs for DME.

[2] 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 manual 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 Appendices B and C of this manual. State Medicaid Director Letter #11-003 CMS policy on provider appeals of denials of payment for HCPCS/CPT codes billed in Medicaid claims due to the Medicaid NCCI methodologies.

[3] These files are posted in the "Medicaid NCCI Methodologies" folder on the secure RISSNET portal. States cannot use the Medicaid NCCI files posted on the NCCI Medicaid webpage on the Medicaid.gov website.

[4] Section 6507 of the Affordable Care Act (ACA) 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 Appendices B and C of this manual.

[5] See sections 8.0-8.2 of this manual.

[6] See section 7.4.2 of this manual.

[7] See section 7.4.2 of this manual.

States are required to implement and use in paying all applicable Medicaid claims (regardless of the DOS), 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 MES 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 MES.

2.1 Appeals

States are not required to have a formal appeal process to address claim denials. However, states must 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.

2.2 Savings Reports

States are not required to submit to CMS estimates of savings from applying Medicaid NCCI methodologies.

If states would like to estimate savings for state-level internal purposes, states may consult the NCCI MUE/PTP Edit Savings Guidance for State Medicaid Agencies available in the Helpful Educational Materials section of the Medicaid National Correct Coding Initiative webpage.

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 MES. CMS does not advocate any one 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 MES. However, each state Medicaid agency is responsible for ensuring that whatever method it chooses to use in its MES is fully compliant with all federal requirements for state implementation of the NCCI methodologies.[8]

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[8] 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:

4.0 Enhanced Federal Financial Participation for MMIS

Section 1903(r) of the Social Security Act (SSA), as amended by section 6507 of the ACA, describes the functionality of a state's MES or a state's information retrieval and automated claims payment processing system. With the enactment of this section of the ACA, state MES 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 MES system.

Thus, in considering revisions to a state's MES, CMS is authorized to reimburse a state 90 percent of its costs to upgrade and update its MES 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 MES that are 100 percent owned by the state. Federal funds cannot be used for any MES component that is proprietary, i.e., partially or fully owned by a private entity.[9]

5.0 Scope of Application of the Medicaid NCCI Methodologies

5.1 Types of Medicaid Claims to which the NCCI Methodologies are Applicable

The Medicaid NCCI methodologies must be applied 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 an FFS basis in state Medicaid Primary Care Case Management (PCCM) managed care programs. Application of NCCI methodologies to FFS claims processed by limited benefit plans or Managed Care Organizations (MCOs) is desirable but optional. Concerning Medicare crossover claims[10], paid claim lines on crossover claims processed by the A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs and forwarded to the states are not to be subjected to Medicaid NCCI edits. Denied claim lines on claims processed by the A/B MACs and DME MACs must be subjected to Medicaid NCCI edits. This includes denied lines that are forwarded to the states as part of a crossover claim or claim lines that were denied by the MACs and subsequently submitted to the states as

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- 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.

[9] A state can request enhanced FFP for the costs of upgrading/updating its MES 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).

[10] Crossover claims are claims for services rendered to beneficiaries who are enrolled in both Medicare and Medicaid. Those claims are submitted first to the MACs. After Medicare has made a determination on whether and what to pay, the claims are forwarded to Medicaid for its determination of whether any of the charges that were not paid by Medicare are payable by Medicaid.

new Medicaid claims. MACs have already applied Medicare NCCI edits to most claims. It is optional for the states to apply Medicaid PTP DME edits to DME crossover claims from the MACs. The Medicare DME MACs do not currently apply PTP DME edits. All lines on claims received from Medicare Advantage Part C plans for beneficiaries on the Medicare Part C Dual-Eligible Special Needs Plan (D-SNAP) should be subjected to Medicaid NCCI edits. Since Medicare Advantage Part C plans are not required to implement Medicare NCCI edits, states are encouraged, although not required, to subject all crossover claims from those entities to Medicaid NCCI edits.

5.2 Types of Medicaid Claims to which the Medicaid NCCI Methodologies are not Applicable

The Medicaid NCCI methodologies are not applicable to 4 categories of Medicaid claims:[11]

- Medicaid claims which are not submitted using HCPCS/CPT codes, e.g., claims which are submitted using revenue codes and National Drug Codes (NDCs)
- Medicaid claims that are submitted on the American Dental Association Dental Claim Form
- 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
- 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 Providers Whose Claims Must Be Subjected to Application of the Medicaid NCCI Methodologies[12]

Under the authority of section 6507 of the ACA, State Medicaid Director Letter #10-017 requires states to use the Medicaid NCCI methodologies for paying applicable Medicaid 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).
- Providers of durable and home medical equipment.

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[11] 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.

[12] This section defines the types of claims subject to the Medicaid NCCI edits, 1 of the 4 components of the Medicaid NCCI methodologies.

5.4 Managed Care[13]

State Medicaid managed care programs include 3 forms of Medicaid managed care: PCCM, MCOs, and limited benefit plans. Application of the Medicaid NCCI methodologies to PCCM 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 Three Principal Types of Medicaid Managed Care

Managed Care Type/Type of Data Submitted	Monthly Payment includes	Method/Who pays Service Providers	Use of NCCI edits
PCCM/Claims	Case Management Services; may include additional coordinated care services	FFS/PCCM or State	Mandatory
MCO/Encounters	All or most Medicaid services	Contract, sub-capitation, bundled, global payment/MCO	Optional
Limited Benefit Plans/Claims or encounters	Limited Medicaid services	Contract/Limited Benefit Plan	Optional

5.4.1 Primary Care Case Management

In Primary Care Case Management (PCCM), 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. The Primary Care Case Manager also provides primary care services to the assigned Medicaid beneficiaries. The state Medicaid agency reimburses on an FFS basis the Primary Care Case Manager for the primary care services provided by the Primary Care Case Manager 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

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[13] The information in this section applies to organizations in their role as an 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 (FFS) 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 FFS claims.

claims that result from the Medicaid NCCI edits must be characterized as denials of payment due to the Medicaid NCCI edits.

5.4.2 MCOs

In a risk-based managed-care arrangement, the state Medicaid agency pays an MCO a monthly prepaid amount for each Medicaid enrollee, which covers all or most Medicaid-covered services provided to each enrollee. The MCO may reimburse those who provide covered services to the Medicaid enrollees on an FFS, contract, 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 an 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 contains 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 an FFS basis, or if an MCO that pays claims on an FFS basis chooses to use the Medicaid NCCI methodologies, even though there is no requirement to do so, those denials must 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.

5.5 Additional Types of Providers Whose Claims May Be Subjected to Application of the Medicaid NCCI Methodologies

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. These optional types of providers include, but are not limited to, the following:

- Physician office-based laboratories, independent clinical laboratories, independent radiology facilities, and independent diagnostic testing facilities.
- 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

Table 2 (page 12) provides guidance to states on the Medicaid NCCI methodology that must 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 5 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 2 types of providers listed in the table on page 12.

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

Provider type	Mandatory/Optional	CMS 1500 or 837P Claim form or equivalent; Rendering Practitioner Identified/Not Identified	UB 04 or 837I Claim Form or Equivalent Submitted
Physician Practitioner[14]	Mandatory	PRA[15]/PRA	OPH[16]
Nonphysician Practitioner[17]	Mandatory	PRA/PRA	OPH
Ambulatory Surgical Center (ASC)	Mandatory	PRA/PRA	PRA
Outpatient Services in Hospitals[18]	Mandatory	OPH/OPH	OPH
Durable/Home Medical Equipment[19]	Mandatory	DME[20]/DME	DME
Nonhospital-Based Testing Facilities[21]	Optional	PRA/PRA	PRA
Other Providers of Outpatient Services[22]	Optional	PRA/OPH	OPH

[14] Physician practitioners include doctor of medicine and osteopathy, podiatrists, optometrists, chiropractors, and dentists. This includes applicable Medicaid claims for outpatient series and for services provided to inpatient in hospitals and to residents of nursing homes.

[15] The Medicaid NCCI methods with PTP edits and MUEs for PRA and ASC services.

[16] The Medicaid NCCI methods with PTP edits and MUEs for outpatient services in hospitals.

[17] Examples include but are not limited to nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse midwives, physician assistants, clinical psychologists, clinical social workers, physical therapists, occupational therapists and speech-language pathologists. It is important that each state consult its Medicaid State Plan to ensure that edits are applied to all nonphysician practitioners within the state. Edits are applicable to Medicaid claims for outpatient services and for services provided to inpatients in hospitals and to residents of nursing homes.

[18] Services provided to outpatients in emergency rooms, observations units, clinics, laboratories, and radiology departments in hospitals, as well as other diagnostic and therapeutic services provided to outpatients in hospitals.

[19] NCCI DME methods are mandatory to claims for DME, prosthetics, orthotics, and supplies submitted by all providers of outpatient services. Identical edits for the Medicaid NCCI methods are found in standalone DME edit files and the PRA and OPH files. States have the option to use the DME edits from any of these edits files to apply to Medicaid DME claims, as the DME edits are the same within the 3 PTP edit files and the 3 MUE files.

[20] The Medicaid NCCI methods with PTP edits and MUEs for durable/home medical equipment.

[21] E.g., physician office-based laboratories, independent clinical laboratories, independent radiology facilities, and independent diagnostic testing facilities.

[22] E.g., Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) Community Mental Health Centers (CMHC), comprehensive 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.

7.0 Edits

States are required to use the Medicaid NCCI edit files for processing and payments applicable to Medicaid claims. The Medicare NCCI edit files cannot be used as a substitute because the differences between the 2 sets of NCCI edit files are significant and increase in content over time. Examples of the differences include the following:

- Medicare has some non-published/confidential MUEs. However, there are no confidential or un-published edits in the Medicaid NCCI program.
- MUEs for the same code may have different values in the Medicare and Medicaid NCCI programs.
- The Medicaid NCCI program has PTP edits for DME; the Medicare NCCI program does not.
- The Medicaid NCCI program has PTP edits and MUEs for codes that are not covered or not separately payable by the Medicare program.

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.

7.1 Complete Edit Files

States must download the NCCI edit files that are available on the secure RISSNET portal. The publicly available files located on the [Medicaid National Correct Coding Initiative webpage](#) are not for use by states. More information is contained in Appendices E and F of this manual.

The general public and providers may use the publicly available Medicaid NCCI edit files available on the [Medicaid NCCI Edit Files webpage](#).

7.1.1. Final Quarterly Edit Files

States must download the NCCI edit files that are available on the secure RISSNET portal. The publicly available files located on the [Medicaid NCCI Edit Files webpage](#) are not for use by states.

All PTP edits contained in the final quarterly Medicaid NCCI edit files for states obtained on the secure RISSNET portal are also contained in the Medicaid NCCI edit files for the current calendar quarter which is posted on the [Medicaid NCCI Edit Files webpage](#).

The final quarterly Medicaid NCCI MUE files posted for states on the secure RISSNET portal contain both the MUEs that are currently in effect and the MUEs that have been deleted and are no longer in effect. The quarterly Medicaid NCCI MUE files that are posted on the NCCI Medicaid webpage on the Medicaid.gov do not contain the MUEs that are no longer in effect. CMS only posts the current quarter file and the previous quarter's file. These files may be found on the [Medicaid NCCI Edit Files webpage](#).

Table 3: Differences in the Fields in the Medicaid NCCI Edit Files Posted on the NCCI Medicaid webpage on the Medicaid.gov Website and on the RISSNET Portal

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

Approximately 45 days before the beginning of a new calendar quarter, CMS posts the final, complete, quarterly Medicaid NCCI files on the secure 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 2020 edit files were not implemented until February 7, 2020, the state must reprocess claims that were previously processed from 01/01/2020 through 02/06/2020.

A state Medicaid agency must use the most recent final quarterly Medicaid NCCI files that have been posted on the secure RISSNET portal for processing and paying Medicaid claims. For example, a state must use the Medicaid NCCI edits in Medicaid NCCI edit files for the first quarter of 2020 for claims that are processed and paid from 01/01/2020 through 03/31/2020, regardless of the DOS on the claim.

If a state's MES is processing a Medicaid claim with a DOS in an earlier calendar quarter, the MES must process the claim with the Medicaid NCCI edit files for the current calendar quarter that are posted for states on the secure RISSNET portal, 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 secure RISSNET portal 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 DOS of the Medicaid claim, the Medicaid NCCI edit must 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 contains an effective date. If the NCCI program deleted an edit, the deletion date for the edit is equal to or subsequent to the implementation date and contained in every subsequent quarterly Medicaid NCCI edit file for states.

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[23] Exception: The PTP edit rationale is also included in the Fixed-Width ASCII text files on the secure RISSNET portal, but not in the Tab-Delimited ASCII text files or the Excel files on the secure RISSNET portal.

Every quarterly Medicaid NCCI edit file contains a version date, which is the first day of the calendar quarter for which the file is effective. 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 DOS of the claim. For example, the version date for the edits contained in the state Medicaid NCCI edit files for the second quarter of 2020 is April 1, 2020. These edits must be applied to claims that are processed by a state between April 1, 2020, and June 30, 2020. [24]

If a claim falls within the range of processing dates for that version of the Medicaid NCCI edit files, then the edit must look at the DOS on the claim line and only apply the Medicaid NCCI edit if the DOS 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 DOS on a claim was 12/27/2020 and the claim is processed on 01/03/2021, then the Medicaid NCCI edit files with a version date of 01/01/2021 must be used in processing the claim. However, Medicaid NCCI edits with an effective date of 01/01/2021 contained in the Medicaid NCCI edit files with a version date of 01/01/2021 must not be applied to that claim. Medicaid NCCI edits with a deletion date before 12/27/2020 contained in the Medicaid NCCI edit files with a version date of 01/01/2021 must 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 secure RISSNET portal. COTS vendors do not have direct access to this website or to these files. States are notified of all Medicaid NCCI program information and edit files through the secure portal on the secure RISSNET portal.

Note: State Medicaid Agencies (SMAs) must download NCCI edit files available on the RISSNET secure portal rather than using the publicly available files. SMAs must ensure that they or their vendor are using the appropriate Medicaid NCCI edits to adjudicate Medicaid claims. The files on the NCCI Medicaid webpages are for providers and the general public. States cannot use the publicly available files for processing and paying Medicaid claims. NCCI edit files available on the RISSNET secure portal contain additional information necessary for correct claims processing by SMAs. SMA use of the publicly available files that do not contain edit history may result in improper payment and/or inappropriate denials. Correspondence Language Example Identifiers (CLEID) contained in the files on the RISSNET secure portal are not included in the public files. CLEIDs support the rationale for each edit during the claims processing and adjudication process. General information on CLEIDs and examples of CLEIDs are available in the Correspondence Language Manual for Medicaid on the Medicaid National Correct Coding Initiative webpage.

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

7.1.2 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 secure 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 Edit Files webpage](#), i.e., MUEs that are no longer in effect, their effective date and deletion date, the effective date of current MUEs, and the CLEID for PTP edits and MUEs.

A state Medicaid agency may share these quarterly state Medicaid NCCI edit files which are posted on the secure RISSNET portal with the contracted fiscal agent that processes its FFS claims or with any of its contracted Medicaid managed-care entities that is using 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, only when appropriate confidentiality agreements are in place. The state Medicaid agency need not have a direct contract with such vendors.

A state Medicaid agency may share quarterly state Medicaid NCCI edit files with state auditors if appropriate confidentiality agreements are in place.

Information about quarterly changes in the Medicaid NCCI edit files which is posted in the change-report files and which appear on the [Medicaid NCCI Edit Files webpage](#) at the beginning of each calendar quarter may not be released prior to this time.

7.1.3 Confidentiality Agreements Requirements for Contracted Parties

Contracted Parties is defined as a fiscal agent that has a contract with the state Medicaid agency for processing its claims, or any Medicaid managed care entities, its contractor or subcontractor (including COTS software vendors) which assist with implementation of claims processing or encounter data, and who must use these edit files for processing purposes. Contracted parties also include state auditors.

At a minimum, the following elements must be included in the confidentiality agreements for any contracted party using the Medicaid NCCI files posted on the secure RISSNET portal:

- Disclosure shall be limited to only those responsible for the implementation of the quarterly state Medicaid NCCI edit files.
- After the start of the new calendar quarter, a Contracted Party may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the NCCI Medicaid webpage.
- The Contracted Party agrees to use any non-public information from the quarterly state Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies in the particular state.

- New, revised, or deleted Medicaid NCCI edits shall not be published or otherwise shared with individuals, medical societies, or any other entities unless it is a Contracted Party prior to the posting of the Medicaid NCCI edits on the NCCI Medicaid webpage.
- Implementation of new, revised, or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter.
- Only a state Medicaid agency has the discretion to release additional information for selected individual edits or limited ranges of edits from the files posted on the secure RISSNET portal.
- State Medicaid agencies must impose penalties, up to and including loss of contract, for violations of any confidentiality agreement relating to use of the secure RISSNET portal edit files.

7.1.4. Medicaid-Only NCCI Edits

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

States will have 45 days from the date of posting to review and comment on the edits. States should review the quarterly Medicaid-only NCCI edit change reports and files to determine if there are any conflicts with state laws, regulations, administrative rules, or payment policies. The review of, and comment on, the edits should consider the appropriateness of the edits based on NCCI coding policies.

If a state disagrees with the edits, it should send its comments in writing to the NCCI contractor at NCCIPTPMUE@cms.hhs.gov. The NCCI program contact information may be found on the Medicaid National Correct Coding Initiative webpage.

The comments from the state must clearly identify the edits being questioned. 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.

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

For PTP edits, if a state's claims processing system is set so that the Column Two code in a PTP edit will deny even if 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, to prevent unintended denial of the Column Two code. If a state's claims processing system is set so that the PTP edit will be bypassed if 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.

7.2 Change Report Files

Change Report files identify added, deleted, and revised PTP edits and MUEs for a calendar quarter. Approximately 45 days before the beginning of a new calendar quarter, CMS posts the complete edit files and Change Reports for that quarter on the secure RISSNET portal. Approximately 30 days before the beginning of a new calendar quarter, CMS posts the complete edit files and Change Reports for that quarter on the [Medicaid NCCI Edit Files webpage](#). The reports posted on both websites are identical.

The fields on the PTP edit Change Reports are: Column 1, Column 2, Modifier Indicator. The fields on the MUE Change Reports are: HCPCS/CPT Code, MUE Value.

A state Medicaid agency must 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 secure RISSNET portal for each new calendar quarter are complete replacements of the Medicaid NCCI edit files for prior calendar quarters. Refer to paragraph in section 7.1.1 for instructions regarding application of changed edits to previous calendar quarters.

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

There are 4 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 DOS
- Other state-specific edits

CMS requires states and contracted vendors to apply the 3 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

State-specific screening edits are sometimes used to review a claim for completeness.

Examples of what screening edits look for:

- Required information

- Invalid entries (e.g., invalid HCPCS/CPT codes, modifiers that are inappropriately appended to a HCPCS/CPT code)
- Beneficiary enrollment in the state's Medicaid program on the DOS
- Provider enrollment in the state's Medicaid program on the DOS
- Duplicate claim/claim line

7.3.2 State-Specific PTP Edits and UOS Edits Which Address Services Rendered on the Same DOS Which Must Be Applied After the Medicaid NCCI Edits

PTP edits are edits in which payment of one code is denied because another code is billed by the same provider for the same DOS 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 PTP edits addressing services performed on the same DOS.
- Incompatible and/or mutually exclusive procedures.

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 DOS.
- Edits for services that require prior authorization, for which more than one unit of service could be authorized, for a single DOS.
- Medical necessity or utilization review edits addressing services provided on the same DOS.

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

States may choose to apply additional state-specific 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 DOS.
- Benefit-limit edits addressing more than a single DOS.

- Services that require prior authorization and for which more than one unit of service could be authorized, and the authorization addresses more than a single DOS.
- Services that require prior authorization and which would always be for one unit of service.
- Edits which determine whether the state's Medicaid program covers the service billed for that Medicaid beneficiary on that DOS 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, sex, age).
- Medical necessity edits and utilization review edits which address services provided on more than a single DOS.
- 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 must 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 impacted by an NCCI-related claim denial shall be subject to the standard state appeals or claim resubmission process(es). A state Medicaid agency may override a denial of payment for a specific Medicaid claim (i.e., an individual case exception) resulting from any Medicaid PTP edit or MUE if the provider submits appropriate documentation and manual medical 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
- 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.

7.4.2 Deactivation of Individual Medicaid NCCI Edits for One State

It is possible that state laws, regulations, administrative rules, and payment policies may conflict with NCCI edits. If a state finds that one or more Medicaid NCCI edits conflict, the state can consider making any necessary changes to its policies prior to the scheduled implementation of the edits. The state should also determine whether there are other codes that are more appropriate, whether there is a solution compliant with HIPAA and coding rules, and whether analyzing their state data reveals a cost-effective solution. Additionally, states should review their state-specific edits prior to requesting an NCCI edit deactivation. If the value of a state UOS edit for a particular HCPCS/CPT code is less than the MUE value for that code, a deactivation request is not required. If after this analysis the state continues to find that the Medicaid NCCI edit(s) conflict, the state may submit a NCCI edit deactivation request to CMS for consideration and approval.

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 uses a state-specific edit and 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.
- 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 unit of service 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. 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.

If the state determines and documents that there is no other feasible way to comply with Medicaid NCCI edits, the state can send a request to deactivate that edit or those individual edits to the NCCI Contractor using the NCCI program mailbox at NCCIPTPMUE@cms.hhs.gov.

All requests for CMS' approval to deactivate Medicaid NCCI edits must include the following information and documentation:

1. A list of the specific new or revised Medicaid PTP edits or MUEs for which CMS' approval for deactivation is being requested.
2. Specification of whether the requested deactivation is for practitioner (PRA), outpatient hospital (OPH), or durable medical equipment (DME) edits.
3. The rationale for the requested deactivation, including documentation and analysis of other options as appropriate.
4. A copy of, or link to, the state law, regulation, administrative rule, or payment policy that conflicts with the new or revised Medicaid PTP edits or MUEs.

Deactivation of an edit allows means that the state's MES is to be reprogrammed 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.

States can make deactivation requests at any time. However, CMS encourages states to allow sufficient time for the review of deactivation requests by CMS prior to the scheduled implementation of new and revised Medicaid NCCI edits. (Effective April 2017, the Medicaid NCCI Advance Planning Document [APD] is no longer used for submitting deactivation requests.)

States are also able to comment on NCCI edits before they become effective. Medicaid NCCI edit files are released 45 days prior to implementation for the following calendar quarter. Proposed new Medicaid-only edits are posted to the secure RISSNET portal. States have 45 days from the date of posting to review and send comments to CMS on the proposed edits.

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 the supporting documentation listed in Section 7.4.2 and/or support from the medical literature (if applicable) to the NCCI Contractor using the NCCI program mailbox at NCCIPTPMUE@cms.hhs.gov. If the request is for reconsideration of an MUE, the state is encouraged to propose an alternative value for the MUE. The NCCI Contractor will analyze the request and documentation and make a recommendation to CMS, which will make the final decision.

7.5 PTP Edits

7.5.1 Scope of Applicable Medicaid Claims Needed for PTP 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 MES must be able to identify all HCPCS/CPT codes billed by the same provider for the same Medicaid beneficiary on the same DOS 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 PTP Edit

A state's MES must 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 must 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 must 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 CCMI of 0 are both billed by a provider on 1 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 1 of the specified NCCI PTP-associated modifiers is added to 1 of the 2 codes of the PTP edit.[25] When the 2 services are provided in separate encounters, both services will be eligible for payment.

7.5.3 PTP Edits for Immunization Administration and Preventive Medicine Services

(Pertinent parts of this section will be included in the Medicaid NCCI Coding Policy Manual, Chapter 11).

7.5.4 Procedure for States to Request CMS Approval to Deactivate Individual PTP Edits

A state may request through the NCCI program mailbox at NCCIPTPMUE@cms.hhs.gov, 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:

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[25] Section 8.1 of this manual specifies the NCCI PTP-associated modifiers.

- 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.
- When the state's MES 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 Appendix B of this manual, NCCI PTP edits must be applied to a code pair only if the Column One code is eligible for payment. If it is not, the PTP edit must be bypassed. However, if a state's MES 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, to prevent unintended denial of payment of the Column Two code. If a state's MES 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.

7.5.5 State-Specific PTP Edits

A state is allowed to apply 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.[26] 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.

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[26] Refer to Sections 7.3 – 7.3.3 for more information on order of edits.

7.6 UOS Edits and MUEs

7.6.1 UOS Edits in General[27]

A UOS edit is defined by at least 6 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 & Management (E&M) codes]; or per unit of time [e.g., per 15 minutes or per day]).
- 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 may allow all UOS up to the value of the UOS edit to be paid; UOS billed above that value will not be paid. [28]

7.6.2 MUEs

NCCI MUEs are UOS edits.

A CMS NCCI MUE is defined by the following elements:

- The HCPCS or CPT code
- A value
- An effective date
- 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.

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[27] All UOS edits are assumed here to apply to claim lines and claims for the same beneficiary. This includes MUEs.

[28] 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 MUEs. The claim-adjudication rule required by CMS for the NCCI MUEs is given in the following section.

If a Medicaid claim contains the same HCPCS/CPT code and the same DOS 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 DOS.

If a provider bills the same HCPCS/CPT code on the same DOS 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 DOS.

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. MUEs define, the maximum UOS reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service.

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 2 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 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.[29] However, the modifier that is used must not be one of the designated PTP-associated modifiers.[30]

However, appending any state-specified modifier to a HCPCS/CPT code must 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 1 line of a Medicaid claim is 2. If the number

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[29] See Appendix C
[30] Listed in section 8.1 of this manual.

of UOS billed for that code on that 1 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 MUEs 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 07/01/2020 and the To date is 07/10/2020. 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 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 MUE 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 8.

Billing CPT code 90472 always requires billing CPT code 90471. Consequently, the maximum UOS allowed by the combination of MUE values for these 2 CPT codes is 9 and payment will be denied only if the number of vaccine/toxoid injections given to the same beneficiary on the same day is 10 or more.

If 10 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 2 lines of a Medicaid claim or can appeal denial of payment through the state's appeals process.

Alternatively, a state Medicaid agency can request Deactivation of the Medicaid MUE for code 90472, if state policy allows more than 8 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 MUEs 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 MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB). If the bilateral surgery indicator is 1, a bilateral surgical procedure must be reported with 1 unit of service and modifier 50, bilateral modifier. 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 2 claim lines (e.g., 1 with the RT modifier and 1 unit of service and the other with the LT modifier and 1 unit of service), but this is not the recommended approach.

For radiologic procedures, other non-surgical diagnostic procedures, and DME 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 2 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 MUEs with a Value of 0

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

- The 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 PRA MUE will not be 0.
- The OPH MUE may be 0 for an E&M code that specifies an inpatient hospital service. The corresponding PRA MUE will not be 0.
- 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 some situations, the Medicaid MUE is 0 based on Medicare policy. If payment for a HCPCS/CPT code on a 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 a Medicaid 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.[31]

7.6.3 State-Specific UOS 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 DOS), 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 DOS) 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. If the value of a state UOS edit for a particular HCPCS/CPT code is less than the MUE value for that code, a deactivation request is not required.

7.7 CLEIDs and Edit Rationales

Each NCCI PTP edit and MUE has a corresponding 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 for each Medicaid NCCI edit is in the Medicaid NCCI edit files that CMS posts on the secure RISSNET portal. The CLEIDs are not in the Medicaid NCCI edit files that CMS posts on the NCCI Medicaid website. Detailed information about CLEIDs is in the Medicaid NCCI

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[31] See section 7.4.1.

[Correspondence Language Manual](#) that CMS posts on the [Medicaid National Correct Coding Initiative webpage](#).

In addition, Medicaid NCCI edit files on the [Medicaid NCCI Edit Files webpage](#) contain rationale for each Medicaid NCCI MUE. MUE rationale is not included in the files that CMS posts on the secure 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 a paid primary code that is performed by the same practitioner for the same beneficiary on the same DOS. An Add-on Code (AOC) 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.

AOC 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 AOC 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 MES all modifiers for HCPCS codes and CPT codes needed for the correct adjudication of applicable Medicaid claims.

8.1 Modifiers Associated with PTP 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, only when 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 1 of these modifiers to a HCPCS/CPT code that is 1 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.[32] Modifiers 24, 25, and 57 should only be appended to an E&M code (99202–99499, 92002–92014), regardless of

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[32] Modifiers 24 and 57 are used with Evaluation & Management (E&M) codes only when the related code is a surgery service.

whether the E&M code is the Column One or Column Two 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 DOS, a state's MES 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.

MLN Matters® [MLN1783722](MLN1783722) contains information on the proper use of modifiers 59 or XE, XP, XS, XU. Additional information about modifiers 59 or XE, XP, XS, XU is found in Section E of Chapter 1 of the Medicaid NCCI Policy Manual.

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 MES 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 1 of the codes also has modifier 59, a PTP edit with a CCMI of "1" should be bypassed.

8.2 Modifiers Associated with MUEs

Refer also to Section 7.6.2.3 MUEs for Bilateral Procedures and Items

The modifier that has a direct impact on the adjudication of Medicaid claims with MUEs is modifier 55.[33] 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 MES 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

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[33] This differs from the claim-adjudication rules for NCCI PTP edits. These rules direct that the PTP edit be bypassed, if the CCMI for the edit is "1" and if one of the 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.

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 2 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.

Appendix A: Acronyms

ACA: Affordable Care Act

AOC: Add-On Code

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

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

DOS: Date of Service

E&M: Evaluation & Management

FFP: Federal Financial Participation

FFS: Fee-For-Service

FQHC: Federally Qualified Health Center

HCPCS: Healthcare Common Procedure Coding System

MCO: Managed Care Organization

MES: Medicaid Enterprise Systems (MES) (formerly known as MMIS)

MII: Medicaid Integrity Institute

MMIS: Medicaid Management Information System

MUE: Medically Unlikely Edit

NCCI: National Correct Coding Initiative

NDC: National Drug Code

NPI: National Provider Identifier

OPH: Outpatient Hospital

OPPS   Hospital Outpatient Perspective Payment Systems

PCCM: Primary Care Case Management

PRA: Practitioner

PTP: Procedure-to-Procedure

RHC: Rural Health Clinic

SMA: State Medicaid Agency

SSA: Social Security Act

TGM: Technical Guidance Manual

UOS: Units of Service

Appendix B: Procedure-to-Procedure Edits – Edit Characteristics and Claim Adjudication Rules

NCCI PTP Edit Characteristics

1. NCCI Procedure-to-Procedure (PTP) edits apply to services by same provider to same beneficiary on same date of service (DOS). The edits apply regardless of whether the codes are reported on the same claim or on different claims.
2. Each edit consists of a code pair (Column One code and Column Two code), a 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.
   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 (CCMI)
      (i) 0 – Edit cannot be bypassed with an NCCI PTP-associated modifier. (See sections below on NCCI PTP-Associated Modifiers and Claim Adjudication Rules.)
      (ii) 1 – Edit may be able to be bypassed with an NCCI PTP-associated modifier. (See sections below on NCCI PTP-Associated Modifiers and Claim Adjudication Rules.)
      (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.
3. The presence of a HCPCS/CPT code in a PTP edit does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs.

NCCI PTP-Associated Modifiers

The NCCI PTP-associated modifiers are the following:

Anatomical modifiers: RT, LT, E1 – E4, FA, F1 – F9, TA, T1 – T9, LC, LD, LM, RC, RI

Non-anatomical modifiers: 24, 25, 27, 57, 58, 59, 78, 79, 91, XE, XP, XS, XU

The state's claims processing system must recognize all of these modifiers and allow the PTP edit to be bypassed, if any of these modifiers are appended to the appropriate code of the edit pair with a modifier indicator of 1 and if the other conditions specified in the Claim Adjudication

Rules section below are met. Failure to do this will result in incorrect denials of payment that will be incorrectly attributed to the NCCI program.

PTP-associated modifiers may be appended only when appropriate, based on clinical circumstances, and in accordance with the NCCI program and HCPCS/CPT Manual instructions/definitions for the modifier/procedure code combination. For example, modifier 25 (significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should only be appended to an E&M code (99202–99499, 92002–92014), regardless of whether the E&M code is the Column One or Column Two code. It would never be appropriate for use with other codes, such as surgery codes.

The Medicaid NCCI program does not require that modifiers 59 or XE, XP, XS, XU be appended to the Column Two code of a PTP edit. It may be appended to either the Column One or the Column Two code. States, providers, and other interested parties should also refer to the MLN Matters® MLN1783722 and the NCCI Policy Manual for Medicaid Services for specific information regarding modifier use, which can be found in the Helpful Educational Materials section on the Medicaid National Correct Coding Initiative webpage.

NCCI PTP Claim Adjudication Rules

1. Apply edits to claims for services by the same provider to the same beneficiary on the same DOS.

2. Determine whether type of claim and site of service are subject to the NCCI PTP edits.

    A. The Practitioner (PRA) NCCI PTP edit file should be applied to Medicaid claims from practitioners, in which a unique provider identification number for an individual practitioner is associated with each claim line, regardless of the site of service, and ambulatory surgical centers.
    B. The Outpatient Hospital (OPH) NCCI PTP edit file should be applied to Medicaid claims from outpatient hospitals and for facility (hospital) emergency department, observation, and hospital laboratory services.
       (i) States have the option of applying the OPH NCCI PTP edit file to provider types other than those described in (2)(a), (2)(b), or (2)(d) that submit claims in which a unique provider number for an individual practitioner is not associated with each claim line.
       (ii) Either the Durable Medical Equipment (DME), PRA, or OPH NCCI PTP edit file should be applied to Medicaid claims for DME, prosthetics, orthotics, and supplies. Identical edits for these items are present in all 3 of these files.

3. For each HCPCS/CPT code submitted on a claim, identify all other HCPCS/CPT codes submitted on the current claim or earlier claims in history with the same DOS

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 PTP edit files.

 (i) 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 PTP edit file for the relevant site of service.

 (ii) After code pairs that match NCCI PTP edits in the edit file are identified, test the DOS against the effective date and deletion date (if relevant) for each edit. Apply the NCCI PTP edit to the claim only if the DOS is "on or after" the effective date and "on or before" the deletion date of the edit. Most edits do not have deletion dates. Exception: Bypass the edit if the effective date and the deletion date are the same. (The effective date and deletion date are the same for edits that have been deleted retroactively).

 (iii) After code pairs that match PTP edits in the edit file with dates of service within the effective period of the corresponding edit are identified, determine whether the Column One code is eligible for payment. Apply the NCCI PTP edit to the claim only if the Column One code is eligible for payment. Bypass the PTP edit if it is not.

 (iv) After code pairs that match NCCI PTP edits in the edit file with dates of service within the effective period of the corresponding edit and with a Column One code that is eligible for payment are identified, determine whether an NCCI PTP associated modifier is correctly appended to either or both of the codes of the code pair. Proceed as follows:

  a. If the modifier indicator of the edit is 0, the Column Two code is denied (not payable) regardless of whether an NCCI PTP-associated modifier is appended. These edits cannot be bypassed.

  b. If the modifier indicator of the edit is 1 and if no NCCI PTP-associated modifier is correctly appended to either code, the Column Two code is denied.

  c. If the modifier indicator of the edit is 1 and if an NCCI PTP-associated modifier is correctly appended to an appropriate code in the edit, the PTP edit is bypassed and the Column Two code is eligible for payment. An exception to this rule is that if both codes have the same anatomical modifier (see above) and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is NOT bypassed and the Column Two code is denied.

  d. 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.

(v) If a code is denied because of an NCCI PTP edit, a denial message should be added to the code denial on the provider payment notice. Some recommendations for Provider Payment Notice Advice alternatives are as follow:

    a. "Payment denied based on NCCI edit."

    b. "Payment denied because service not payable with another service on the same DOS."

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

(vi) There should also be a notice on the claim payment advice indicating that the denied service should not be billed to the beneficiary. The denied service is a provider liability. Providers cannot use any type of an "Advanced Beneficiary Notice" or "Waiver" form to obtain payment from beneficiary.

Because reported HCPCS/CPT codes for the same DOS on the current claim are tested with all other codes with the same DOS from claims in history, it is possible that an NCCI PTP edit will be triggered where the Column One code on the current claim is payable and the Column Two code that should have been denied was previously paid from a claim in history that was adjudicated earlier. In this situation, the claims processor must see to it that the prior inappropriate payment for the Column Two code is recouped, offset, or otherwise adjusted, so that the provider receives appropriate payment for only the Column One code.

A state's MES must apply NCCI edits at the appropriate point in the sequence of claim processing edits. Details of the required order of edits are found in the Medicaid NCCI Technical Guidance Manual (TGM), Sections 7.3 – 7.3.3.

Appendix C: Medically Unlikely Edits – Edit Characteristics and Claim Adjudication Rules

Medically Unlikely Edit (MUE) Characteristics

1. An MUE is a unit of service unit of service edit for a HCPCS/CPT code that applies to services performed by the same provider for the same beneficiary on the same date of service (DOS).
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 DOS edit. It is not applied to the sum of all UOS for a code with the same DOS.
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 the 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. Exception: Bypass the edit if the effective date and the deletion date are the same. (The effective date and deletion date might be the same for edits that have been deleted retroactively.)
   D. 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 are subject to the edit. Claims with dates of service after the deletion date are not subject to the edit. Exception: Bypass the edit if the effective date and the deletion date are the same.
   E. CLEID – Correspondence Language Example Identification number for correspondence.
   F. Publication Indicator – This indicator enables a claims processor to determine whether an MUE value is published. If the value is not published on the CMS website, it is a confidential MUE value and should not be shared with/released to anyone other than Medicaid Fiscal Agent contractors with a valid need for the MUE value. Medicaid currently does not have any confidential/non-published MUE values. However, confidential/non-published Medicaid MUEs may be implemented at a later date.
5. The presence of an MUE value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any or all state Medicaid programs.

MUE Claim Adjudication Rules

1. Apply edits to services by same provider for same beneficiary on same DOS.
2. Determine whether the type of claim and the site of service are subject to MUE edits.
   A. The Practitioner (PRA) MUE file should be applied to Medicaid claims from practitioners, in which a unique provider identification number for an individual

practitioner is associated with each claim line, regardless of the site of service, and ambulatory surgical centers.

    B. The Outpatient Hospital (OPH) MUE file should be applied to Medicaid claims from outpatient hospitals and for facility (hospital) emergency department, observation, and hospital laboratory services.

    C. States have the option of applying the MUE OPH file to provider types other than those described in (2)(a), (2)(b), or (2)(d) that submit claims in which a unique provider number for an individual practitioner is not associated with each claim line.

    D. Any 1 of the Durable Medical Equipment (DME), PRA, or OPH MUE files should be applied to Medicaid claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Identical edits for these items are present in all 3 of these files.

3. An MUE is a claim line edit that compares the UOS reported for the HCPCS/CPT code on the claim line to the MUE value for that code.

4. If the UOS on the claim line are less than or equal to the MUE value assigned to the HCPCS/CPT code, the UOS pass the MUE.

5. If the UOS on the claim line is greater than the MUE value assigned to the HCPCS/CPT code, 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 to the To date 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 processor should divide the reported UOS 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 submitted UOS. For example, the provider bills a HCPCS/CPT code which has an MUE value of 1. The From date listed on the claim is 02/01/2021 and the To date listed on the claim is 02/10/2021. The submitted UOS on the claim are 14. The From and To dates equal 10-day date span. The number of UOS (14) should be divided by the number of days in the date span (10) to determine the "per day" UOS. In this example, the "per day" UOS equal 1.4. Rounding to the nearest whole number makes the "per day" unit of service equal 1, which should pass the MUE edit. However, a claim with the same From and To dates as that listed above (10-day date span) billed with 20 submitted UOS would calculate to equal "2" UOS per day. This number exceeds the MUE value for the code and the entire claim line should be denied.

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 payment notice. For example, UOS exceed the MUE.

8. There should also be a notice on the provider claim payment advice indicating that a denied service should not be billed to the beneficiary. Providers cannot use any type of Recipient Waiver of Liability or Advanced Beneficiary Notice to obtain payment from the beneficiary.

9. Caution: Since an MUE is a claim line edit, not an entire claim edit, the claims processor should not sum all UOS for a HCPCS/CPT code on the claim or for the

same DOS from prior claims in history with same DOS and compare this number to the MUE value.

10. Caution: A provider may report the same code on more than one claim line, when appropriate, 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 processors may consider developing duplicate claim line logic to prevent providers from misusing modifiers to report the same code on more than 2 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: The MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB).

14. For radiologic procedures, other non-surgical diagnostic procedures, and DME 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 2 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.

A state's MES should apply NCCI edits at the appropriate point in the sequence of claim processing edits. Details of the required order of edits are found in the Medicaid NCCI Technical Guidance Manual (TGM), Sections 7.3 – 7.3.3.

Appendix D: File Types and File Names

File Types

There are 2 types of National Correct Coding Initiative (NCCI) edits:

- NCCI Procedure-to-Procedure (NCCI PTP) edits
- Medically Unlikely Edits (MUEs) units of service (UOS)

NCCI PTP files and MUE files are prepared for 3 provider types:

- Practitioner (PRA)
- Outpatient Hospital (OPH)
- Durable Medical Equipment (DME)

NCCI PTP and MUE files are prepared for posting to 2 websites:

- The secure Regional Information Sharing Systems (RISSNET) portal, funded by the United States Department of Justice. These files can only be accessed by state Medicaid programs.
- The Medicaid NCCI Edit Files webpage.

There are 2 sets of files:

- Complete edit files – contain a complete replacement file for each quarter's NCCI PTP edits and MUEs
- Change Report files – contain a list of only the additions, deletions, revisions, and correct coding modifier indicator (CCMI) changes for the quarterly release

RISSNET Files – File Formats

The NCCI PTP and MUE complete edit files posted to the secure RISSNET portal are prepared in 3 file formats to allow greatest flexibility for state Medicaid program claims processors implementing the edits.

- Each file format contains the same records although there may be some difference in the detail or the order of some of the fields. However, the essential information is identical.
- Each claims processor should select the file format that best suits their need and use that format consistently when retrieving and implementing the edits.

The 3 formats are:

- Fixed-Width ASCII text
- Tab-delimited ASCII text
- Excel

The PTP and MUE Change Report files posted to the secure RISSNET portal are prepared in 2 formats:

- Tab-delimited ASCII text
- Excel

Publicly Available Files – File Formats

The quarterly NCCI PTP and MUE complete edit files posted to the Medicaid NCCI Edit Files webpage are posted as data tables.

The quarterly NCCI PTP and MUE complete edit files and Change Report files posted to the Medicaid NCCI Edit Files webpage are prepared in 2 file formats.

- Each file format contains the same records.
- Each user can select the file format that best suits their need.

The 2 formats are:

- Tab-delimited ASCII text
- Excel

Important Notes:

- State Medicaid agencies shall only use the quarterly Medicaid NCCI complete edit files that are posted on the secure RISSNET portal to process their Medicaid claims and not the publicly available files posted on the CMS website.
- States shall not use the Change Report files to update their NCCI edit files.

File Names

Complete Edit Files

For the complete edit files posted to the secure RISSNET portal, the naming convention that will be used is:

- Payer - MCD = Medicaid
- Type of Edit - PTP or MUE
- Provider type - PRA (Practitioner), OPH (Outpatient Hospital), or DME (Durable Medical Equipment)

- Version number – Year and quarter # (1, 2, 3, 4)
- Release type and rendition number – F = Final – e.g., F1 = first rendition of final file (If there is a subsequent revision to a quarterly file, it would be designated F2.)
- Format - T = Fixed-Width ASCII Text; D = Tab-Delimited ASCII Text; E = Excel
- File extension - .txt – Fixed-Width ASCII Text and Tab-Delimited ASCII Text; .xlsx – Excel

The PRA and OPH Excel files are posted in 2 parts because they exceed the Excel limit for rows in a single document.

For example, the initial final versions of the January 2021 RISSNET files were named:

```
MCD-PTP-PRA-v2021q1-F1-T.txt
MCD-PTP-PRA-v2021q1-F1-D.txt
MCD-PTP-PRA-v2021q1-F1-E-Part 1.xlsx
MCD-PTP-PRA-v2021q1-F1-E-Part 2.xlsx
MCD-PTP-OPH-v2021q1-F1-T.txt
MCD-PTP-OPH-v2021q1-F1-D.txt
MCD-PTP-OPH-v2021q1-F1-E-Part 1.xlsx
MCD-PTP-OPH-v2021q1-F1-E-Part 2.xlsx
MCD-PTP-DME-v2021q1-F1-T.txt
MCD-PTP-DME-v2021q1-F1-D.txt
MCD-PTP-DME-v2021q1-F1-E.xlsx

MCD-MUE-PRA-v2021q1-F1-T.txt
MCD-MUE-PRA-v2021q1-F1-D.txt
MCD-MUE-PRA-v2021q1-F1-E.xlsx
MCD-MUE-OPH-v2021q1-F1-T.txt
MCD-MUE-OPH-v2021q1-F1-D.txt
MCD-MUE-OPH-v2021q1-F1-E.xlsx
MCD-MUE-DME-v2021q1-F1-T.txt
MCD-MUE-DME-v2021q1-F1-D.txt
MCD-MUE-DME-v2021q1-F1-E.xlsx
```

For the complete edit Publicly Available files posted to the CMS Medicaid NCCI Edit Files webpage, see Appendices E and F for the format.

Change Report Files:

For Change Report files posted to the secure RISSNET portal and the CMS Medicaid website, Medicaid.gov, the naming convention that will be used is:

- Payer - MCD = Medicaid

- Type of Edit - PTP or MUE
- Provider type – Practitioner Services (PRA), Outpatient Hospital Services (OPH), or DME (DME)
- Change Type – Additions (Adds), Deletions (Dels), Revisions (Revs), CCMI (modifier indicator) changes
- Effective date – Effective mmddyyyy
- File extension - .txt – Tab-Delimited ASCII Text or .xlsx – Excel

For example, the January 2021 Change Report files were named:

MCD_PTP_PRA_Adds_Eff_01-01-2021.txt
MCD_PTP_PRA_Dels_Eff_01-01-2021.txt
MCD_PTP_PRA_CCMI_Changes_Eff_01-01-2021.txt
MCD_PTP_PRA_Changes_Eff_01-01-2021.xlsx

MCD_PTP_OPH_Adds_Eff_01-01-2021.txt
MCD_PTP_OPH_Dels_Eff_01-01-2021.txt
MCD_PTP_OPH_CCMI_Changes_Eff_01-01-2021.txt
MCD_PTP_OPH_Changes_Eff_01-01-2021.xlsx

MCD_PTP_DME_Adds_Eff_01-01-2021.txt
MCD_PTP_DME_Dels_Eff_01-01-2021.txt
MCD_PTP_DME_CCMI_Changes_Eff_01-01-2021.txt
MCD_PTP_DME_Changes_Eff_01-01-2021.xlsx

MCD_MUE_PRA_Adds_Eff_01-01-2021.txt
MCD_MUE_PRA_Dels_Eff_01-01-2021.txt
MCD_MUE_PRA_Rev_Eff_01-01-2021.txt
MCD_MUE_PRA_Changes_Eff_01-01-2021.xlsx

MCD_MUE_OPH_Adds_Eff_01-01-2021.txt
MCD_MUE_OPH_Dels_Eff_01-01-2021.txt
MCD_MUE_OPH_Rev_Eff_01-01-2021.txt
MCD_MUE_OPH_Changes_Eff_01-01-2021.xlsx

MCD_MUE_DME_Adds_Eff_01-01-2021.txt
MCD_MUE_DME_Dels_Eff_01-01-2021.txt
MCD_MUE_DME_Rev_Eff_01-01-2021.txt
MCD_MUE_DME_Changes_Eff_01-01-2021.xlsx

Note: In the text (.txt) format, each Change Report is formatted individually. Therefore, additions, deletions, revisions, and CCMI changes are contained in separate files. The Excel (.xlsx) format contains a single file with a separate tab for each change type i.e., additions (Adds), deletions (Dels), revisions (Revs), CCMI Changes (CCMIChgs).

**Appendix E: File Formats – Procedure-to-Procedure Edits**

RISSNET Formats – NCCI PTP Complete Edit Files

The NCCI Procedure-to-Procedure (PTP) complete edit files are posted to the secure RISSNET portal in 3 formats. The specifications for each format and sample screen prints have been included on the following pages. The 3 formats are:

1. Fixed-Width ASCII Text
2. Tab-Delimited ASCII Text
3. Excel

Fixed-Width ASCII Text Format

1. In the NCCI PTP RISSNET edit files in fixed-width ASCII text format, each edit will have the following format:
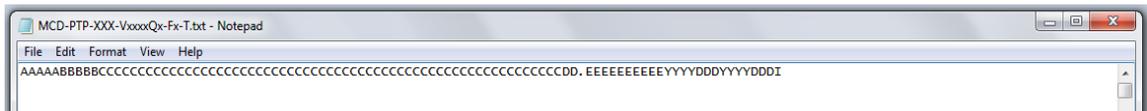
2. There will be 3 separate final NCCI PTP RISSNET edit files. Their file names will be:
   a. Practitioner (PRA)/ASC NCCI PTP edit file: MCD-PTP-PRA-vXXXXqX-FX-T.txt
   b. Outpatient Hospital (OPH) NCCI PTP edit file: MCD-PTP-OPH-vXXXXqX-FX-T.txt
   c. Durable Medical Equipment (DME) NCCI PTP edit file: MCD-PTP-DME-vXXXXqX-FX-T.txt

   Note: Refer to Appendix D for details of file naming convention.

Field Name	Notes	Type	Beg. Char	# of Char
Column 1 code (no label)	AAAAA	Alpha-Numeric Text	1	5
Column 2 code (no label)	BBBBB	Alpha-Numeric Text	6	5

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Field Name	Notes	Type	Beg. Char	# of Char
Standard Policy Statement (no label)	CCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCCCCC Each statement is coded to a policy number. On active edits, this policy number directly relates to the first 2 digits of the CLEID number. A list of the Standard Policy Statements can be found in Appendix G.	Alpha-Numeric Text	11	60
CLEID (no label)	Correspondence Language Example Identification number format: DD.EEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When a PTP edit is terminated, the CLEID will be changed to 13.DELETEPR4, which corresponds to the delete edit language and example in the Correspondence Language Manual.	Alpha-Numeric Text	71	12
Effective Date (no label)	Julian date format: yyyyddd	Numeric	83	7

Field Name	Notes	Type	Beg. Char	# of Char
Deletion Date (no label)	Julian date format: yyyyddd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric	90	7
Correct Coding Modifier Indicator (no label)	Indicated in the example as "I" Valid values = 0, 1, or 9 0 = modifiers not allowed 1 = modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric	97	1

The following is an example of a section of a fixed-width ASCII text NCCI PTP RISSNET edit file:

Tab-Delimited ASCII Text Format

1. In the NCCI PTP RISSNET edit files in tab-delimited ASCII text format, each edit will have the following format:
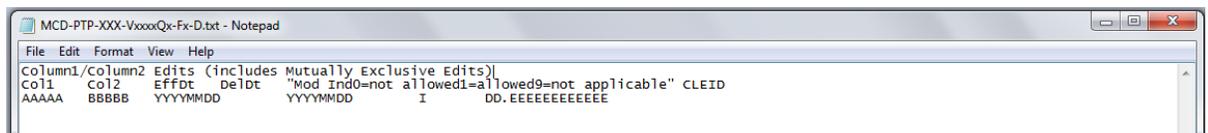
2. There will be 3 separate final NCCI PTP RISSNET edit files. Their file names will be:
   a. PRA/ASC NCCI PTP edit file: MCD-PTP-PRA-vXXXXqX-FX-D.txt
   b. OPH NCCI PTP edit file: MCD-PTP-OPH-vXXXXqX-FX-D.txt
   c. Durable Medical Equipment (DME) NCCI PTP edit file: MCD-PTP- DME-vXXXXqX-FX-D.txt

   Note: Refer to Appendix D for details of file naming convention.

Field Name	Notes	Type	Delimiter	# of Char
Column 1 code (labeled Col1)	AAAAA	Alpha-Numeric Text		5
Column 2 code (labeled Col2)	BBBBB	Alpha-Numeric Text	tab	5
Effective Date (labeled EffDt)	Gregorian – Year (y), Month (m) Day (d) format: yyyymmdd	Numeric	tab	8
Deletion Date (labeled DelDt)	Gregorian – Year (y), Month (m) Day (d) format: yyyymmdd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric	tab	8
Correct Coding Modifier Indicator (labeled Mod Ind)	Indicated in the example as "I" Valid values = 0, 1, or 9 0 = modifiers not allowed 1 = modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric	tab	1

Field Name	Notes	Type	Delimiter	# of Char
CLEID	Correspondence Language Example Identification number format: DD.EEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When a PTP edit is terminated, the CLEID will be changed to 13.DELETEPR4, which corresponds to the deleted edit language and example in the Correspondence Language Manual.	Alpha-Numeric Text	tab	12

Documents and web postings containing these tab-delimited ASCII text files should include the following notification:

Please note – In tab-delimited text files, the records may not align with the column headings or from row to row. This is because of the logic that tells the computer where to place certain values when the data is imported into other applications. For example, on rows for edits that do not have a deletion date, the Correct Coding Modifier Indicator (CCMI) will appear aligned. But, on rows for edits that do have a deletion date, the CCMI will appear to shift to the right. Even though they appear skewed to the reader's eye, from a programming standpoint, the CCMI in both lines will be in the same position.

The following is an example of a section of a tab-delimited ASCII text NCCI PTP RISSNET edit file:

```
MCD-PTP-XXX-VxxxxQx-Fx.txt - Notepad

File  Edit  Format  View  Help
Column1/Column2 Edits (Includes Mutually Exclusive Edits)
Col1    Col2    EffDt   DelDt   "Mod Ind0=not allowed1=allowed9=not applicable" CLEID
29000   29010   20130401                0       4.20000
29000   29015   20130401                0       4.20000
29000   29020   20130401        20141231        0       13.DELETEPR4
29000   29025   20130401        20141231        0       13.DELETEPR4
29000   29035   20130401                0       4.20000

                                                        Ln 8, Col 1
```
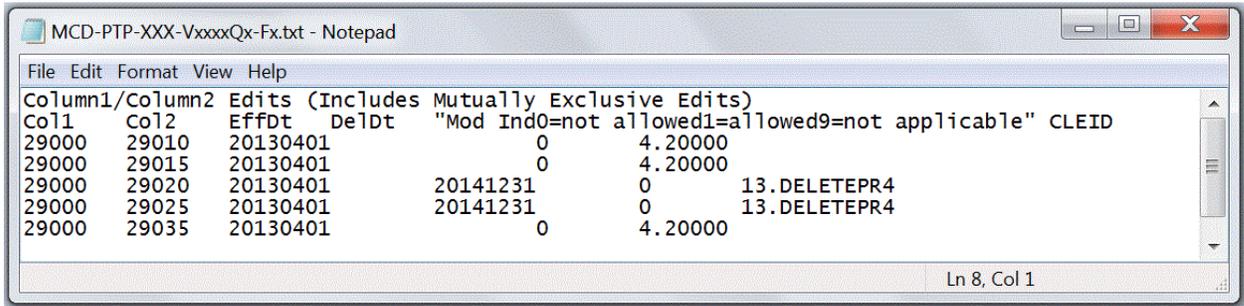
Excel Format

1. In the NCCI PTP RISSNET edit files in Excel format, each edit will have the following format:

	A	B	C	D	E	F
1	Column 1 / Column 2 Edits (Includes Mutually Exclusive Edits)					
2	Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicable	CLE ID
3	AAAAA	BBBBB	YYYYMMDD	YYYYMMDD	I	DD.EEEEEEEEE

2. There will be 2 separate final NCCI PTP RISSNET edit files. Their file names will be:
    a. PRA/ASC NCCI PTP edit file: MCD-PTP-PRA-vXXXXqX-FX-E.xlsx
    b. OPH NCCI PTP edit file: MCD-PTP-OPH-vXXXXqX-FX-E.xlsx
    c. Durable Medical Equipment (DME) NCCI PTP edit file: MCD-PTP-DME vXXXXqX-FX-D.txt

    Note: Refer to Appendix D for details of file naming convention.

Column Name	Notes	Type
Column 1 code (labeled Column 1)	AAAAA	Alpha-Numeric Text
Column 2 code (labeled Column 2)	BBBBB	Alpha-Numeric Text
Effective Date	Gregorian – Year (y), Month (m) Day (d) format: yyyymmdd	Numeric

Column Name	Notes	Type
Deletion Date	Gregorian – Year (y), Month (m) Day (d) format: yyyymmdd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric
Correct Coding Modifier Indicator (labeled Modifier Indicator)	Indicated in the example as "I" Valid values = 0, 1, or 9 0 = modifiers not allowed 1 = modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric
CLEID	Correspondence Language Example Identification number format: DD.EEEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When an edit is terminated, the CLEID will be changed to 13.DELETEPR4, which corresponds to the deleted edit language and example in the Correspondence Language Manual.	Alpha-Numeric Text

Medicaid - Effective 02/28/2025

The following is an example of a section of an Excel NCCI PTP RISSNET edit file:

	A	B	C	D	E	F
1	Column 1 / Column 2 Edits (Includes Mutually Exclusive Edits)					
2	Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicable	CLE ID
3	0001M	36591	20151001	20151001	9	13.DELETEPR4
4	0001M	36592	20151001	20151001	9	13.DELETEPR4
5	0001M	80050	20170401	20181231	0	13.DELETEPR4
6	0001M	80053	20170401	20181231	0	13.DELETEPR4

Publicly Available Format – NCCI PTP Complete Edit Files

The NCCI PTP complete edit files are posted to the CMS Medicaid NCCI website. This page provides links to NCCI Edit files. To download each edit file, just select the desired link. After you select the desired link, the zip file should download. Each zip file contains both text and Excel file(s) formats.

Note: Excel limits the number of rows that can be exported in a single file to 1,048,576 rows. The Practitioner and Outpatient Hospital PTP edit files both contain significantly more rows than that.

To download the complete edit file, save the zip file to your computer and extract the text and Excel file(s). For more information on public files, see the How to use NCCI Tools booklet on the Medicaid NCCI webpages.

Publicly Available and RISSNET Formats – NCCI PTP Change Report Files

The NCCI PTP Change Report files are posted to the CMS Medicaid.gov website and RISSNET in 2 formats. The specifications for each format and sample screen prints have been included on the following pages. The 2 formats are:

1. Tab-Delimited ASCII Text
2. Excel

Tab-Delimited ASCII Text Format

1. In the NCCI PTP Change Report files in tab-delimited ASCII text format, each file will have the following format:

```
*MCD_PTP_XXX_xxxx_Eff_mm-dd-yyyy.txt - Notepad                                                              —   □

File  Edit  Format  View  Help
"The edits in this PTP file are active for dates of service (January 1, 2021 - March 31, 2021). This file should NOT be used by state Medicaid programs
Column 1        Column 2        "ModifierIndicator0=not allowed1= allowed9= not applicable"
AAAAA   BBBBB   I
```

2. There will be 9 separate NCCI PTP Change Report files in this format. The tab-delimited ASCII text Publicly Available files do not indicate a version number, but rather include the date the file becomes effective.

3. In this format, there will be separate files for each provider type (PRA/OPH/DME) and for each change type (additions, deletions, CCMI changes). Refer to Appendix D for details of the file naming convention and the complete list of file names.

Field Name	Notes	Type	Delimiter	# of Char
Column 1 code (labeled Col1)	AAAAA	Alpha-Numeric Text	Tab	5
Column 2 code (labeled Col2)	BBBBB	Alpha-Numeric Text	tab	5
Correct Coding Modifier Indicator (labeled Mod Ind)	Indicated in the example as "I" Valid values = 0, 1, or 9 0 = modifiers not allowed 1 = modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric	tab	1

The following is an example of a section of a tab-delimited ASCII text NCCI PTP Change Report file:

```
MCD_PTP_XXX_xxxx_Eff_mm-dd-yyyy.txt - Notepad                                                              —   □    ×

File  Edit  Format  View  Help
"The edits in this PTP file are active for dates of service (January 1, 2021 - March 31, 2021). This file should NOT be used by state Medicaid programs as t ∧
Column 1        Column 2        "ModifierIndicator0=not allowed1= allowed9= not applicable"
0001U   0071U   1
0001U   0140U   1
0001U   0141U   1
0001U   0142U   1
0001U   0155U   1
0001U   0156U   1
0001U   0157U   1
0001U   0158U   1
0001U   0159U   1
0001U   0160U   1
0001U   0161U   1
0001U   0169U   1
0001U   0177U   1
0001U   0212U   1
0001U   0213U   1
0001U   81168   1
0001U   81191   1
0001U   81192   1
```

Documents and web postings containing these tab-delimited ASCII text files should include the following notification:

Please note – In tab-delimited text files the records may not align with the column headings or from row to row. This is because of the logic that tells the computer where to

place certain values when the data is imported into other applications. For example, on rows for edits that do not have a deletion date, the CCMI will appear aligned. But, on rows for edits that do have a deletion date, the CCMI will appear to shift to the right. Even though they appear skewed to the reader's eye, from a programming standpoint, the CCMI in both lines will be in the same position.

Also, note – Depending on whether the end-user has checked or unchecked the format – Word Wrap – option, the AMA Copyright and Disclaimer information that appears on line 2 of the above example may appear as either a single line or as a variable number of lines depending on how the user has the window displayed. Again, this is simply a reader's eye perception. From a programming standpoint, because the AMA Copyright and Disclaimer information is preceded by a quotation mark (") and followed by a quotation mark ("), the computer will recognize this header information as a single unit and treat it accordingly.

Excel Format

1. In the NCCI PTP Change Report file in Excel format, each file will have the following format:

A	B	C
The edits in this PTP file are active for dates of service (January 1, 2021 - March 31, 2021). This file should NOT be used by state Medicaid programs as their edit file. *Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2020 American Medical Association. All rights reserved.* *CPT® is a registered trademark of the American Medical Association.* *Applicable FARS\DFARS Restrictions Apply to Government Use.* *Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.*		
Column 1	Column 2	**Modifier Indicator** 0=not allowed 1= allowed 9= not applicable
AAAAA	BBBBB	I

2. There will be 3 separate NCCI PTP Change Report files. The Excel files do not indicate a version number, but rather include the date the file becomes effective. Each Excel file will contain 3 worksheets/tabs to identify additions, deletions, and CCMI changes. The file names will be:
   a. PRA/ASC NCCI PTP edit file: MCD_PTP_PRA_Changes_Eff_mm-dd-yyyy.xlsx
   b. OPH NCCI PTP edit file: MCD_PTP_OPH_Changes_Eff_mm-dd-yyyy.xlsx

c. Durable Medical Equipment (DME) NCCI PTP edit file:
        MCD_PTP_DME_Changes_Eff_mm-dd-yyyy.xlsx

Note: Refer to Appendix D for complete details regarding file naming conventions.

Column Name	Notes	Type
Column 1 code (labeled Column 1)	AAAAA	Alpha-Numeric Text
Column 2 code (labeled Column 2)	BBBBB	Alpha-Numeric Text
Correct Coding Modifier Indicator (labeled Modifier Indicator)	Indicated in the example as "I" Valid values = 0, 1, or 9 0 = modifiers not allowed 1 = modifiers allowed 9 = Edit terminated retroactively, edit does not apply	Numeric

Notes:

In addition, the Publicly Available files will include the following copyright disclaimer notice in the header of the file:

Note: The format above is copied directly from the Excel format file.

The following is an example of a section of an Excel NCCI PTP Change Report file:

	A	B	C	D	E	F	G
1	The edits in this PTP file are active for dates of service (January 1, 2021 - March 31, 2021). This file should NOT be used by state Medicaid programs as their edit file. Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.						
2	Column 1	Column 2	Modifier Indicator 0=not allowed 1= allowed 9= not applicable				
3	0001U	0071U	1				
4	0001U	0140U	1				
5	0001U	0141U	1				
6	0001U	0142U	1				

MCD_PTP_OPH_Adds_Eff01-01-2021   MCD_PTP_OPH_Dels_Eff01-01-2021   MCDPTP_OPH_CCMIChgs_Eff01-01-21

**Appendix F: File Formats – Medically Unlikely Edits**

RISSNET Formats – MUE Complete Edit Files

The NCCI Medically Unlikely Edit (MUE) complete edit files are posted to the RISSNET secure portal in 3 formats. The specifications for each format and sample screen prints have been included on the following pages. The 3 formats are:

1. Fixed-Width ASCII Text
2. Tab-Delimited ASCII Text
3. Excel

Fixed-Width ASCII Text Format

1. In the MUE RISSNET edit files in fixed-width ASCII format, each edit will have the following format:


```
MCD-MUE-XXX-vXXXXqX-Fx-T.txt - Notepad
File  Edit  Format  View  Help
AAAAAANNNNNDD. EEEEEEEEEYYYYYDDDYYYYYDDDP
```
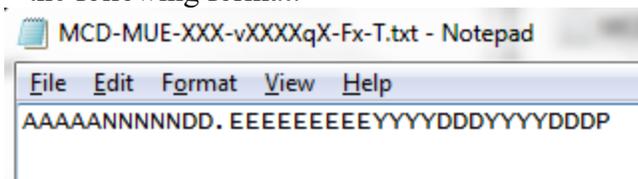
2. There will be 3 separate final MUE RISSNET edit files:
   a. Practitioner (PRA) MUE edit file named MCD-MUE-PRA-vXXXXqX-FX-T.txt. There is one edit file that applies to:
      (i) PRA services, and
      (ii) Ambulatory surgical center (ASC) services
   b. Outpatient Hospital (OPH) MUE edit file named MCD-MUE-OPH-vXXXXqX-FX-T.txt. There is one edit file that applies to:
      (i) OPH claims including DME billed by the hospital (including critical access hospitals)
      (ii) Hospital Facility emergency department claims (including critical access hospitals)
      (iii) Hospital Facility observation services (including critical access hospitals)
      (iv) Hospital Facility outpatient laboratory services (including critical access hospitals)
   c. Durable Medical Equipment (DME) MUE edit file named MCD-MUE-DME-vXXXXqX-FX-T.txt. There is one edit file that applies to:
      (i) DME billed by DME providers
         (a) Does NOT apply to DME billed by practitioners. The MUE file for practitioners contains MUEs for DME billed by a practitioner.
         (b) Does NOT apply to DME billed by hospitals. The MUE file for OPH services contains MUEs for DME billed by a hospital.

   Note: Refer to Appendix D for details of file naming convention.

| Field Name	Notes	Type	Beg. Char.	# of Char.
HCPCS/CPT Code (no label)	AAAAA	Alpha-Numeric Text	1	5
MUE Value (no label)	NNNNN formatted with leading zeros (e.g., an MUE of 11 will be written as 00011)	Numeric	6	5
CLEID (no label)	Correspondence Language Example Identification Number format: DD.EEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When an MUE is terminated, the CLEID will be changed to 16.DELETEPR5, which corresponds to the deleted edit language and example in the Correspondence Language manual.	Alpha-Numeric Text	11	12
Effective Date (no label)	Julian date format: yyyyddd	Numeric	23	7
Deletion Date (no label)	Julian date format: yyyyddd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric	30	7

Field Name	Notes	Type	Beg. Char.	# of Char.
Publication Indicator	P Valid values = 0 or 1 0 = not published – confidential Do not share – for use by CMS/CMCS and its contractors ONLY (currently no MCD MUEs have an indicator = 0) 1 = published - ok to share	Numeric	37	1

The following is an example of a section of a fixed-width ASCII text MUE RISSNET edit file:
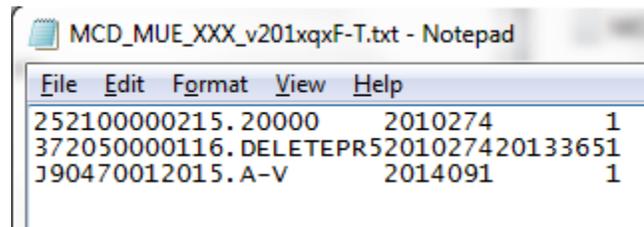
Tab-Delimited ASCII Text Format

1. In the MUE RISSNET edit files in tab-delimited ASCII text format, each edit will have the following format:
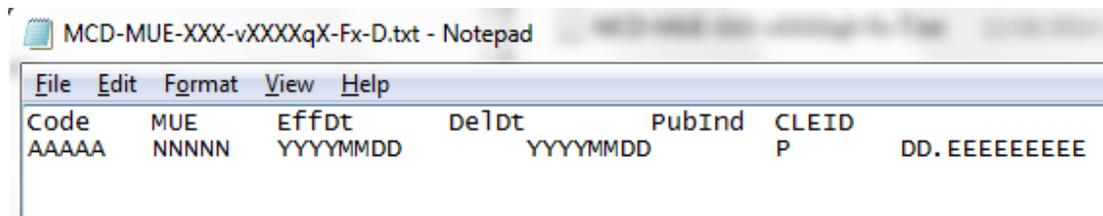
2. There will be 3 separate final MUE RISSNET edit files:
   a. MUE PRA file named MCD-MUE-PRA-vXXXXqX-FX-D.txt. There is one edit file that applies to:
      (i) PRA services, and
      (ii) Ambulatory surgical center (ASC) services.
   b. MUE OPH edit file named MCD-MUE-OPH-vXXXXqX-FX-D.txt. There is one edit file that applies to:
      (i) OPH claims including DME billed by the hospital (including critical access hospitals)

> (ii) Hospital Facility emergency department claims (including critical access hospitals)
> (iii) Hospital Facility observation services (including critical access hospitals)
> (iv) Hospital Facility outpatient laboratory services (including critical access hospitals)
> c. Durable Medical Equipment (DME) MUE edit file named MCD-MUE-DME-vXXXXqX-FX-D.txt. There is one edit file that applies to:
>> (i) DME billed by DME providers
>>> (a) Does NOT apply to DME billed by practitioners. The MUE file for practitioners contains MUEs for DME billed by a practitioner.
>>> (b) Does NOT apply to DME billed by hospitals. The MUE file for OPH services contains MUEs for DME billed by a hospital.

Note: Refer to Appendix D for details of file naming convention.

Field Name	Notes	Type	Delimiter	# of Char.
HCPCS/CPT Code (labeled Code)	AAAAA	Alpha-Numeric Text		5
MUE Value (labeled MUE)	NNNNN formatted with leading zeros (e.g., an MUE of 11 will be written as 00011)	Numeric	tab	5
Effective Date (labeled EffDt)	Gregorian – Year (y), Month (m), Day (d) format: yyyymmdd	Numeric	tab	8
Deletion Date (labeled DelDt)	Gregorian – Year (y), Month (m), Day (d) format: yyyymmdd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric	tab	8
Publication Indicator (labeled PubInd)	P Valid values = 0 or 1 0 = not published – confidential Do not share – for use by CMS/CMCS and its contractors ONLY (currently no MCD MUEs have an indicator = 0) 1 = published - ok to share	Numeric	tab	1

Field Name	Notes	Type	Delimiter	# of Char.
CLEID	Correspondence Language Example Identification Number format: DD.EEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When an MUE is terminated, the CLEID will be changed to 16.DELETEPR5, which corresponds to the deleted edit language and example in the Correspondence Language Manual.	Alpha-Numeric Text	tab	12

Documents and web postings containing these tab-delimited ASCII text files should include the following notification:

Please note – In tab-delimited text files, the records may not align with the column headings or from row to row. This is because of the logic that tells the computer where to place certain values when the data is imported into other applications. For example, on rows for edits that do not have a deletion date, the Publication Indicator will appear aligned, but on rows for edits that do not have a deletion date, the Publication Indicator will appear to shift to the right. Even though they appear skewed to the reader's eye, from a programming standpoint, the Publication Indicator in both lines will be in the same position.

The following is an example of a section of a tab-delimited ASCII text MUE RISSNET edit file:

```
MCD_MUE_XXX_v201xqxF-D.txt - Notepad

File  Edit  Format  View  Help
Code    MUE      EffDt      DelDt          PubInd   CLEID
25210   00002    20101001                  1        15.20000
37205   00001    20101001    20131231      1           16.DELETEPR5
J9047   00120    20140401                  1        15.A-V
```

Note: this example does not represent actual data

Excel Format

1. In the MUE RISSNET edit files in Excel format, each edit will have the following format:

	A	B	C	D	E	F
1	HCPCS\ CPT Code	MUE	Effective Date	Deletion Date	Pub Ind 1 = Ok to Publish 0 = Do Not Share	CLE ID
2	AAAAA	NNNNN	YYYYMMDD	YYYYMMDD	P	DD.EEEEEEEEE

2. There will be 3 separate final MUE RISSNET edit files:
   a. PRA MUE edit file named MCD-MUE-PRA-vXXXXqX-FX-E.xlsx. There is one edit file that applies to:
      (i) PRA services, and
      (ii) Ambulatory surgical center (ASC) services.
   b. OPH MUE edit file named MCD-MUE-OPH-vXXXXqX-FX-E.xlsx. There is one edit file that applies to:
      (i) OPH claims including DME billed by the hospital (including critical access hospitals)
      (ii) Hospital Facility emergency department claims (including critical access hospitals)
      (iii) Hospital Facility observation services (including critical access hospitals)
      (iv) Hospital Facility outpatient laboratory services (including critical access hospitals)
   c. Durable Medical Equipment (DME) MUE edit file named MCD-MUE-DME-vXXXXqX-FX-E.xlsx. There is one edit file that applies to:
      (i) DME billed by DME provider
         (a) Does NOT apply to DME billed by practitioners. The MUE file for practitioners contains MUEs for DME billed by a practitioner.

(b) Does NOT apply to DME billed by hospitals. The MUE file for OPH services contains MUEs for DME billed by a hospital.

Note: Refer to Appendix D for details of file naming convention.

Column Name	Notes	Type
HCPCS/CPT Code	AAAAA	Alpha-Numeric Text
MUE Value (labeled MUE)	NNNNN formatted with leading zeros (e.g., an MUE of 11 will be written as 00011)	Numeric
Effective Date	Gregorian –Year (y), Month (m), Day (d) format: yyyymmdd	Numeric
Deletion Date	Gregorian –Year (y), Month (m), Day (d) format: yyyymmdd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric
Publication Indicator (labeled PubInd)	P Valid values = 0 or 1 0 = not published – confidential Do not share – for use by CMS/CMCS and its contractors ONLY (currently no MCD MUEs have an indicator = 0) 1 = published - ok to share	Numeric

Column Name	Notes	Type
CLEID	Correspondence Language Example Identification Number format: DD.EEEEEEEE The first 2 digits correspond to the Standard Policy Statement for the edit. The digits following the "." correspond to the section of the Medicaid Correspondence Language Manual from which an example can be extracted to incorporate into correspondence such as provider inquiry responses. The last 4 characters of the CLEID field may contain empty spaces. When an MUE is terminated, the CLEID will be changed to 16.DELETEPR5, which corresponds to the deleted edit language and example in the Correspondence Language Manual.	Alpha-Numeric Text

The following is an example of a section of an Excel MUE RISSNET edit file:

	A	B	C	D	E	F
1	HCPCS\ CPT Code	MUE	Effective Date	Deletion Date	Pub Ind 1 = Ok to Publish 0 = Do Not Share	CLE ID
2	25210	00002	20101001		1	15.20000
3	37205	00001	20101001	20131231	1	16.DELETEPR5
4	J9047	00160	20190101		1	15.A-V

Note: this example does not represent actual data

Medicaid - Effective 02/28/2025

Publicly Available Format – MUE Complete Edit Files

The NCCI PTP complete edit files are posted to the CMS Medicaid NCCI website. This page provides links to NCCI Edit files. To download each edit file, just select the desired link. After you select the desired link, the zip file should download. Each zip file contains both text and Excel file(s) formats.

Note: Excel limits the number of rows that can be exported in a single file to 1,048,576 rows. The Practitioner and Outpatient Hospital PTP edit files both contain significantly more rows than that.

To download the complete edit file, save the zip file to your computer and extract the text and Excel file(s). For more information on public files, see the How to use NCCI Tools booklet on the Medicaid NCCI webpages.

Publicly Available and RISSNET Formats – MUE Change Report Files

The NCCI MUE Change Report files are posted to the CMS Medicaid.gov website and the secure RISSNET portal in 2 formats. The specifications for each format and sample screen prints have been included on the following pages. The 2 formats are:

(1) Tab-Delimited ASCII Text
(2) Excel Tab-Delimited ASCII Text Format

1. In the MUE Change Report files in tab-delimited ASCII text format, each file will have the following format:

2. There will be 9 separate MUE Change Report files. The tab-delimited ASCII text files do not indicate a version number, but rather include the date the file becomes effective.

3. Refer to Appendix D for the complete list of file names.

Column Name	Notes	Type
HCPCS/CPT Code	AAAAA	Alpha-Numeric Text
MUE Value (labeled MUE)	NNNNN formatted without leading zeros (e.g., an MUE of 11 will be written as 11)	Numeric

The following is an example of a section of a tab-delimited ASCII text MUE Change Report file:
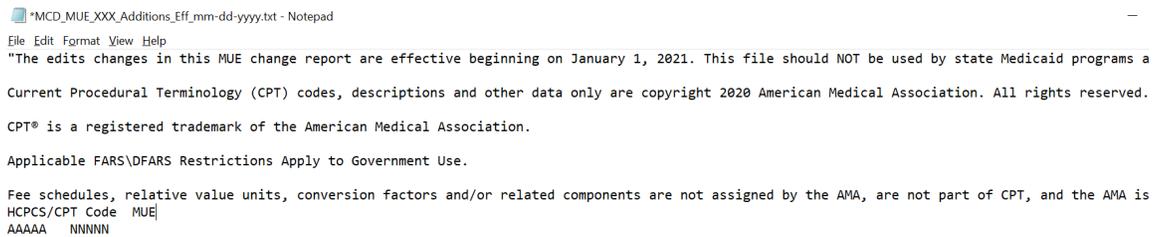

```
MCD_MUE_DME_Additions_Eff_01-01-2021.txt - Notepad                                                           —
File  Edit  Format  View  Help
"The edits changes in this MUE change report are effective beginning on January 1, 2021. This file should NOT be used by state Medicaid programs as

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Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is
HCPCS/CPT Code  DME Supplier Services MUE Values
J1558    1500
```

Please note – Depending on whether the end-user has checked or unchecked the format – Word Wrap – option, the AMA Copyright and Disclaimer information that appears on line 1 of the above example may appear as either a single line or as a variable number of lines depending on how the user has the window displayed. This is simply a reader's eye perception. From a programming standpoint, because the AMA Copyright and Disclaimer information is preceded by a quotation mark (") and followed by a quotation mark ("), the computer will recognize this header information as a single unit and treat it accordingly.

Excel Format

1. In the MUE change Report file in Excel format, each file will have the following format:

A	B
The edits changes in this MUE change report are effective beginning on January 1, 2021. This file should NOT be used by state Medicaid programs as their edit file. Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.	
HCPCS/CPT Code	**MUE**
AAAAA	NNNNN

2. There will be 3 separate MUE Change Report files. The Excel files do not indicate a version number, but rather include the date the file becomes effective. Their file names will be:
   a. PRA/ASC MUE file: MCD_MUE_PRA_Changes_Eff_mm-dd-yyyy.xlsx
   b. OPH MUE file: MCD_MUE_OPH_Changes_Eff_mm-dd-yyyy.xlsx
   c. Durable Medical Equipment (DME) MUE file: MCD_MUE_DME_Changes_Eff_mm-dd-yyyy.xlsx

   Note: In the Excel format additions, deletions, and revisions are contained on separate worksheets within the same file.

3. Refer to Appendix D for the complete list of file names.

Column Name	Notes	Type
HCPCS/CPT Code	AAAAA	Alpha-Numeric Text
MUE Value (labeled MUE)	NNNNN formatted without leading zeros (e.g., an MUE of 11 will be written as 11)	Numeric

The following is an example of a section of an Excel MUE Change Report file:

	A	B	C
1	The edits changes in this MUE change report are effective beginning on January 1, 2021. This file should NOT be used by state Medicaid programs as their edit file. Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2020 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.		
2	HCPCS/CPT Code	DME Supplier Services MUE Values	
3	J1558	1500	
4			
5			
6			
7			
8			

| MCD_MUE DME Adds Eff_01-01-2021 | MCD MUE DME Dels Eff_01-01-2021 | MCD MUE DME Revs Eff_01-01-2021 |

Notes:

In addition, the Publicly Available files will include the following copyright disclaimer notice in the header of the file:

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Note: The format above is copied directly from the Excel format file.

Appendix G: Procedure-to-Procedure Edits – Edit Rationale
(Standard Policy Statements listed by Policy ID number)

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

Appendix H: Medically Unlikely Edits - Edit Rationale

Anatomic Consideration
Clinical: Medicaid Data
Clinical: Medicare Data
Clinical: Society Comment
CMS NCCI Policy
Code Description/CPT Instruction
Drug Discontinued
Inpatient Procedure
Nature of Analyte
Nature of Equipment
Nature of Service/Procedure
Prescribing Information