NGS MU
NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

National Government Services℠

The National Correct Coding Initiative and Medically Unlikely Edits for Part B Providers

6/14/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Arlene Dunphy, CPC
  - Provider Outreach and Education Consultant
- Michelle Coleman, CPC
  - Provider Outreach and Education Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To gain an understanding of NCCI edits and proper modifier use
- Understand the MUE adjudication indicators and how the claims are processed
- Understand the different level of appeals for NCCI and MUE denials

Agenda

- National Correct Coding Initiative
- Modifiers
- Medically Unlikely Edits
- Redetermination/Reopening
- Resources

National Correct Coding Initiative (NCCI)

What Is the NCCI?

- PTP code pair edits
- Developed to promote national correct coding methods
- To control improper coding leading to inappropriate payment for Medicare Part B claims
- Edits to prevent unbundling of services
- Edits are updated quarterly

Coding Conventions Defined

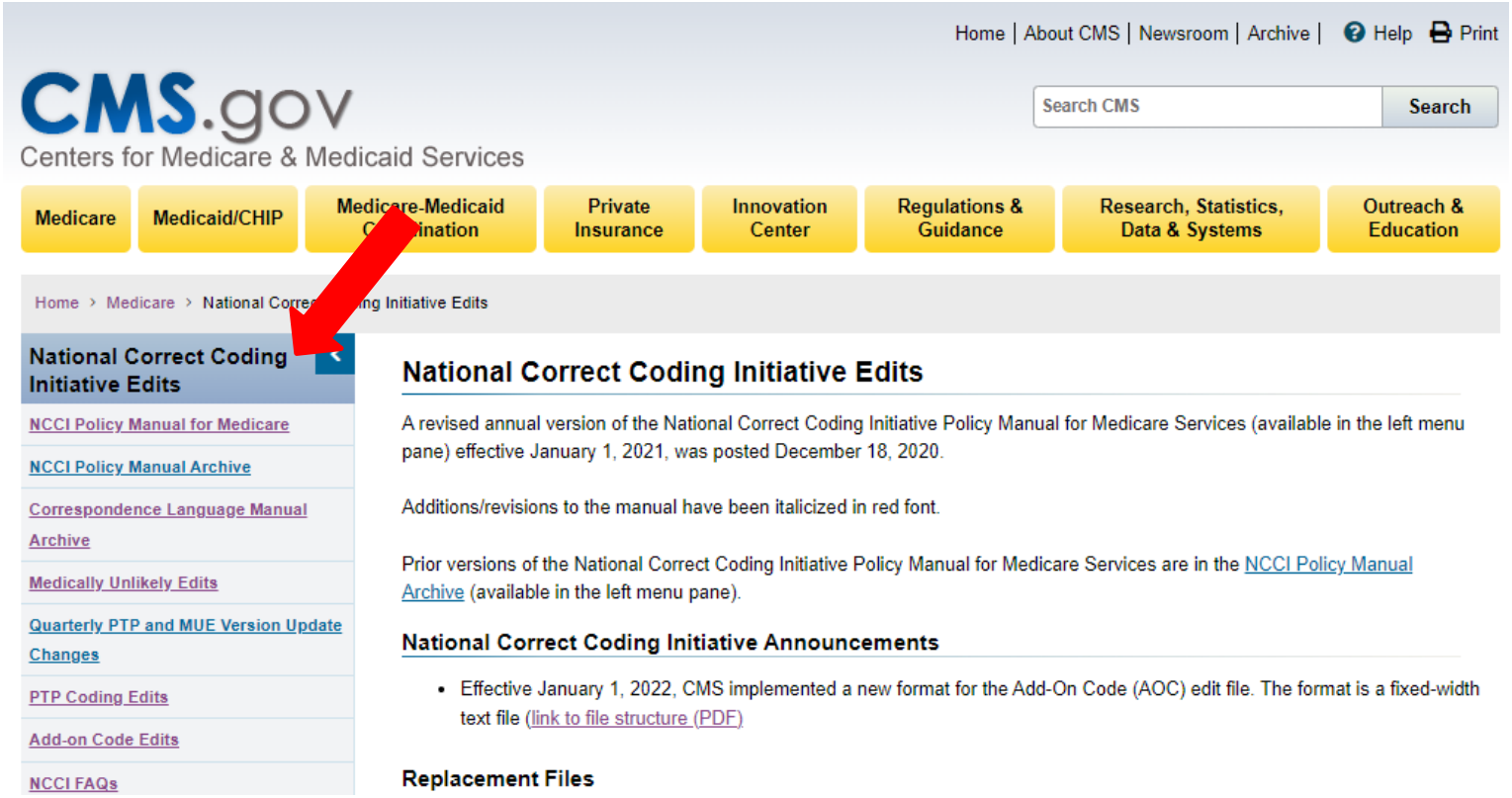
- Coding policies are based on the
  - AMA CPT manual
  - HCPCS manual
  - National and local Medicare policies
  - Coding guidelines developed by national societies

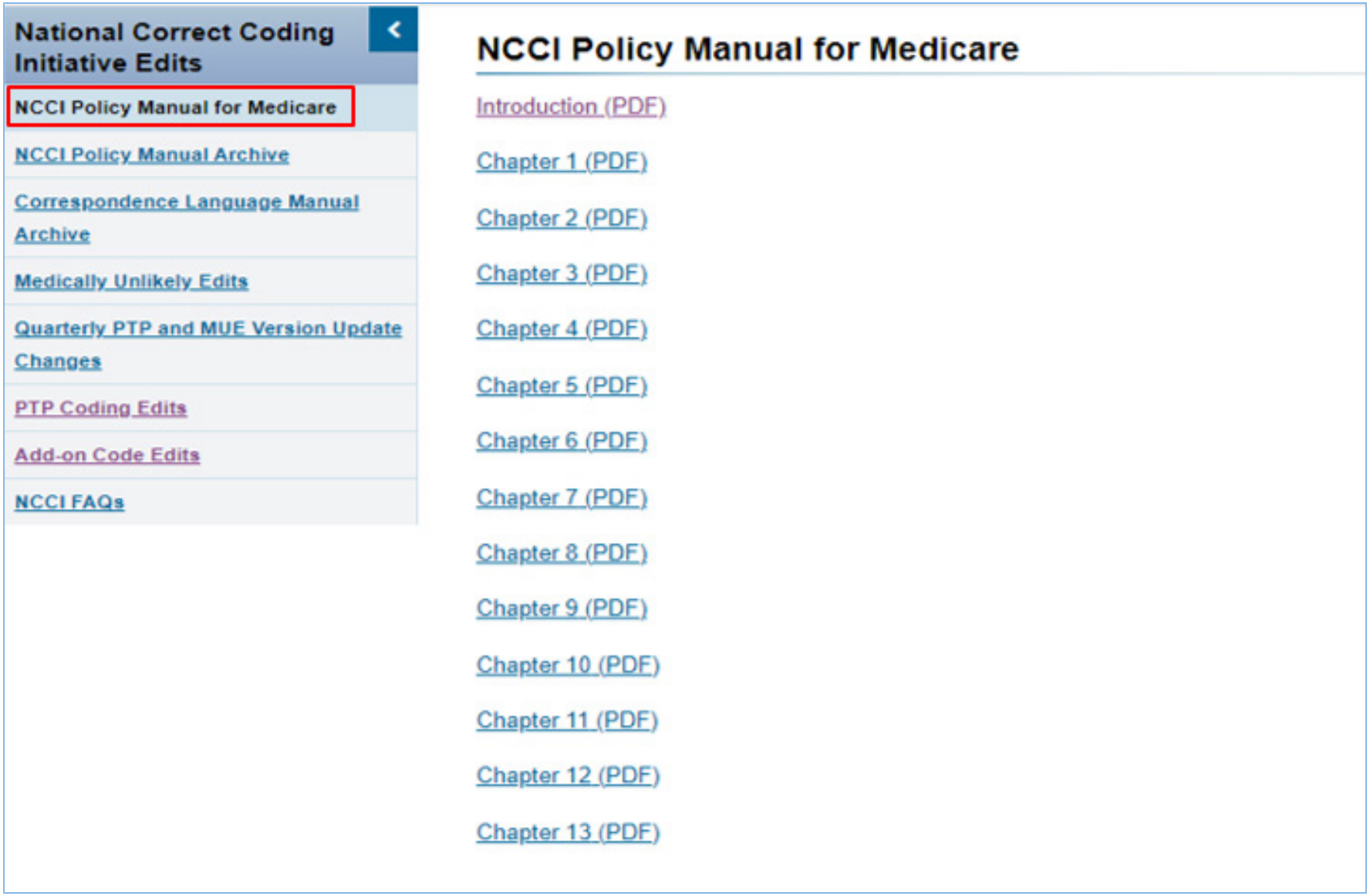
NCCI Edits

- Two types
  - PTP coding edits
    - PTP Edits – physicians
    - PTP Edits – hospitals

Where to Find NCCI Edits

- National Correct Coding Initiative




National Correct Coding Initiative Edits
NCCI Policy Manual for Medicare
NCCI Policy Manual Archive
Correspondence Language Manual Archive
Medically Unlikely Edits
Quarterly PTP and MUE Version Update Changes
PTP Coding Edits
Add-on Code Edits
NCCI FAQs
NCCI Policy Manual for Medicare
Introduction (PDF)
Chapter 1 (PDF)
Chapter 2 (PDF)
Chapter 3 (PDF)
Chapter 4 (PDF)
Chapter 5 (PDF)
Chapter 6 (PDF)
Chapter 7 (PDF)
Chapter 8 (PDF)
Chapter 9 (PDF)
Chapter 10 (PDF)
Chapter 11 (PDF)
Chapter 12 (PDF)
Chapter 13 (PDF)

Where to Find NCCI Edits

Related Links

Hospital PTP Edits v281r0 effective April 1, 2022 (601,681 records) 0001A/0591T – 27894/G0471 (posted 03/01/2022)
Hospital PTP Edits v281r0 effective April 1, 2022 (528,766 records) 28001/0213T - 49999/49570 (posted 03/01/2022)
Hospital PTP Edits v281r0 effective April 1, 2022 (394,805 records) 50010/0213T - 79999/36000 (posted 03/01/2022)
Hospital PTP Edits v281r0 effective April 1, 2022 (213,223 records) 80003/80002 – U0003/U0004 (posted 03/01/2022)
Practitioner PTP Edits v281r0 effective April 1, 2022 (642,540 records) 0001A/0591T – 25999/96523 (posted 03/01/2022)
Practitioner PTP Edits v281r0 effective April 1, 2022 (611,492 records) 26010/01810 – 36909/J2001 (posted 03/01/2022)
Practitioner PTP Edits v281r0 effective April 1, 2022 (590,215 records) 37140/0213T – 60699/96523 (posted 03/01/2022)
Practitioner PTP Edits v281r0 effective April 1, 2022 (662,677 records) 61000/0213T – U0003/U0004 (posted 03/01/2022)
Hospital PTP Edits v280r2 effective January 1, 2022 (598,592 records) 0001A/0591T – 27894/G0471 (posted 02/04/2022)
Hospital PTP Edits v280r2 effective January 1, 2022 (528,742 records) 28001/0213T - 49999/49570 (posted 02/04/2022)
Hospital PTP Edits v280r2 effective January 1, 2022 (394,753 records) 50010/0213T - 79999/36000 (posted 02/04/2022)
Hospital PTP Edits v280r2 effective January 1, 2022 (212,443 records) 80003/80002 – U0003/U0004 (posted 02/04/2022)
Practitioner PTP Edits v280r2 effective January 1, 2022 (639,319 records) 0001A/0591T – 25999/96523 (posted 02/04/2022)
Practitioner PTP Edits v280r2 effective January 1, 2022 (611,489 records) 26010/01810 – 36909/J2001 (posted 02/04/2022)
Practitioner PTP Edits v280r2 effective January 1, 2022 (590,131 records) 37140/0213T – 60699/96523 (posted 02/04/2022)
Practitioner PTP Edits v280r2 effective January 1, 2022 (661,916 records) : 61000/0213T – U0003/U0004 (posted 02/04/2022)

NCCI Coding

- Column one code is eligible for payment
- Column two code will be denied unless both codes are clinically appropriate
- Indicate the supporting documentation in the medical record

NCCI

- Does not include all possible combinations
  - Providers are obligated to code correctly
- Services that are denied based on PTP code pair edits
  - May not be billed to Medicare beneficiaries
  - Cannot utilize an ABN to seek payment

NCCI Indicators

Modifier Indicator	Descriptor
Indicator 0	Codes should never be reported together by the same provider/same beneficiary/same DOS
Indicator 1	Codes may be reported together only in defined circumstances (identified on claims by specific NCCI-associated modifier)
Indicator 9	Not relevant (edit was deleted)

NCCI Example

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
26010	99211		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99212		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99213		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99214		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99215		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99217		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99218		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99219		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99220		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99221		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99222		20130701	*	1	CPT Manual or CMS manual coding instructions
26010	99223		20130701	*	1	CPT Manual or CMS manual coding instructions

NCCI Example

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
93015	90783		19960101	20041231	0	Standards of medical / surgical practice
93015	90784		19960101	20041231	0	Standards of medical / surgical practice
93015	93000		19960101	*	1	Standards of medical / surgical practice
93015	93005		19960101	*	1	Standards of medical / surgical practice
93015	93010		19960101	*	1	Standards of medical / surgical practice
93015	93016		19960101	*	0	HCPCS/CPT procedure code definition
93015	93017	*	19960101	*	0	HCPCS/CPT procedure code definition
93015	93018	*	19960101	*	0	HCPCS/CPT procedure code definition
93015	93040		19960101	*	1	More extensive procedure
93015	93041		19960101	*	1	More extensive procedure
93015	93042		19960101	*	1	More extensive procedure

National Government Services

NGS MU

Remittance Example and References

Code	Description
CO-16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Additional information is supplied using remittance advice remarks codes.
Reason Code 236	This procedure or procedure/modifier combination is not compatible with another procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers' compensation state regulations/fee schedule requirements.

- WPC references
- X12 External Code Lists
  - Remittance Advice Remarks Code reference
  - Claim Adjustment Reason Code reference

National Government Services

NGS MU

Appropriate Modifiers

- Modifiers that may be used under **appropriate clinical circumstances**
  - Anatomic modifiers: E1–E4, FA, F1–F9, TA, T1–T9, LT, RT, LC, LD, RC, LM, RI
  - E/M modifiers: 24, 25, 57
  - Global surgery modifiers: 58, 78, 79
  - Other modifiers: 59, XE, XS, XP, XU, 76, 77, 91, KX
- Documentation must satisfy the criteria required

Repeat Service Modifiers

- Modifier 76 – Repeat procedure by the same physician
- Modifier 77 – Repeat procedure by a different physician
- Modifier 91 – Repeat clinical diagnostic laboratory test to obtain multiple results
- Repeat Procedures – Modifiers 76 and 77
- Proper Use of Modifiers 59 and 91

National Government Services

NGS MU

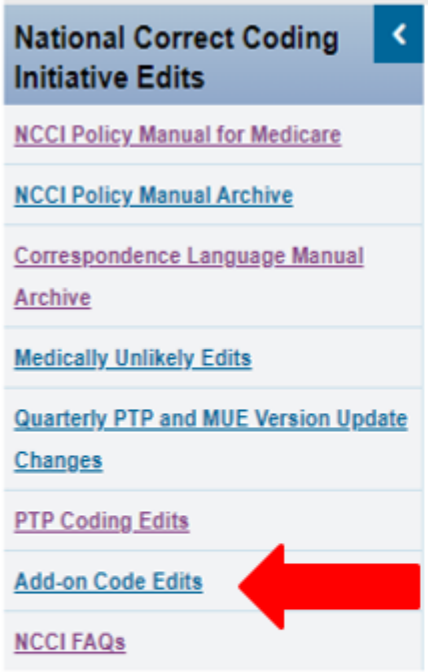
Modifier 59/XE/XS/XP/XU
Distinct Procedural Service

- Used when performed procedure or service distinct or separate from other services performed on same day, such as
  - Different session or patient encounter
  - Different procedure or surgery
  - Different anatomic site
  - Separate lesion
  - Separate injury

Modifiers 59/XE/XS/XP/XU

- Appropriate usage
  - Different session or patient encounter, different procedure or surgery, different anatomical site, or separate injury or area of injury
  - Medical record documentation indicates two separate distinct procedures performed on the same day by the same physician
  - Listed on the column one or column two code (MM11168)
  - Only when there is no other appropriate modifier to use
- Inappropriate usage
  - Code combination does not appear in the NCCI edits
  - Not be appended to an E/M service performed on the same date, see modifier 25
  - NCCI modifier table with a modifier indicator of “0”
  - Medical record documentation does not support the separate and distinct status
  - Exact same procedure code was performed twice on the same day, see modifier 76 or 77
  - A more appropriate modifier exists to identify the services

Add-on Codes



National Correct Coding Initiative Edits

A revised annual version of the National Correct Coding Initiative Policy Manual for Medicare Services (available in the left menu pane) effective January 1, 2021, was posted December 18, 2020.

Additions/revisions to the manual have been italicized in red font.

Prior versions of the National Correct Coding Initiative Policy Manual for Medicare Services are in the NCCI Policy Manual Archive (available in the left menu pane).

National Correct Coding Initiative Announcements

Replacement Files

The CMS issued replacement files with the following changes:

- Replacement Files (4th quarter of 2021, V2) - CMS issued replacement files for NCCI PRA Procedure to Procedure (PTP) for the October 1, 2021 files. Updated public replacement files for Medicare are available using the links in the left navigation pane. (Announcement posted October 1, 2021)
- Replacement Files (1st quarter of 2021) - CMS issued replacement files for NCCI Medically Unlikely Edits (MUEs) for the January 1, 2021 files. Updated public replacement files for Medicare are available using the links in the left navigation pane. (Announcement posted December 14, 2020)
- Replacement MUE Files (3rd quarter of 2020) - CMS issued replacement files for NCCI MUE PRA and NCCI MUE OPH to

National Government Services

NGS MU

Add-on Codes

- Describes a service always performed in conjunction with another primary service
- Is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner
- Is never eligible for payment if it is the only procedure reported by a practitioner

Downloads

How to Use The National Correct Coding Initiative (NCCI) Tools (PDF)

R1421OTN (PDF)

Proper Use of Modifiers 59 & –X{EPSU} (PDF)

Correspondence Language Manual for Medicare Services - Effective date February 28, 2021 (PDF)

Related Links

The National Correct Coding Initiative in Medicaid

HCPCS - General Information

Transmittals

MM8853

SE1422 - Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures

National Government Services

NGS MU

Medically Unlikely Edits

Medically Unlikely Edits

- Developed to reduce the paid claims error rate
- Automated prepayment edits
- Do not exist for all HCPCS/CPT codes
- Majority of the edits are publicly available
- Edits are updated quarterly

MUE Edits

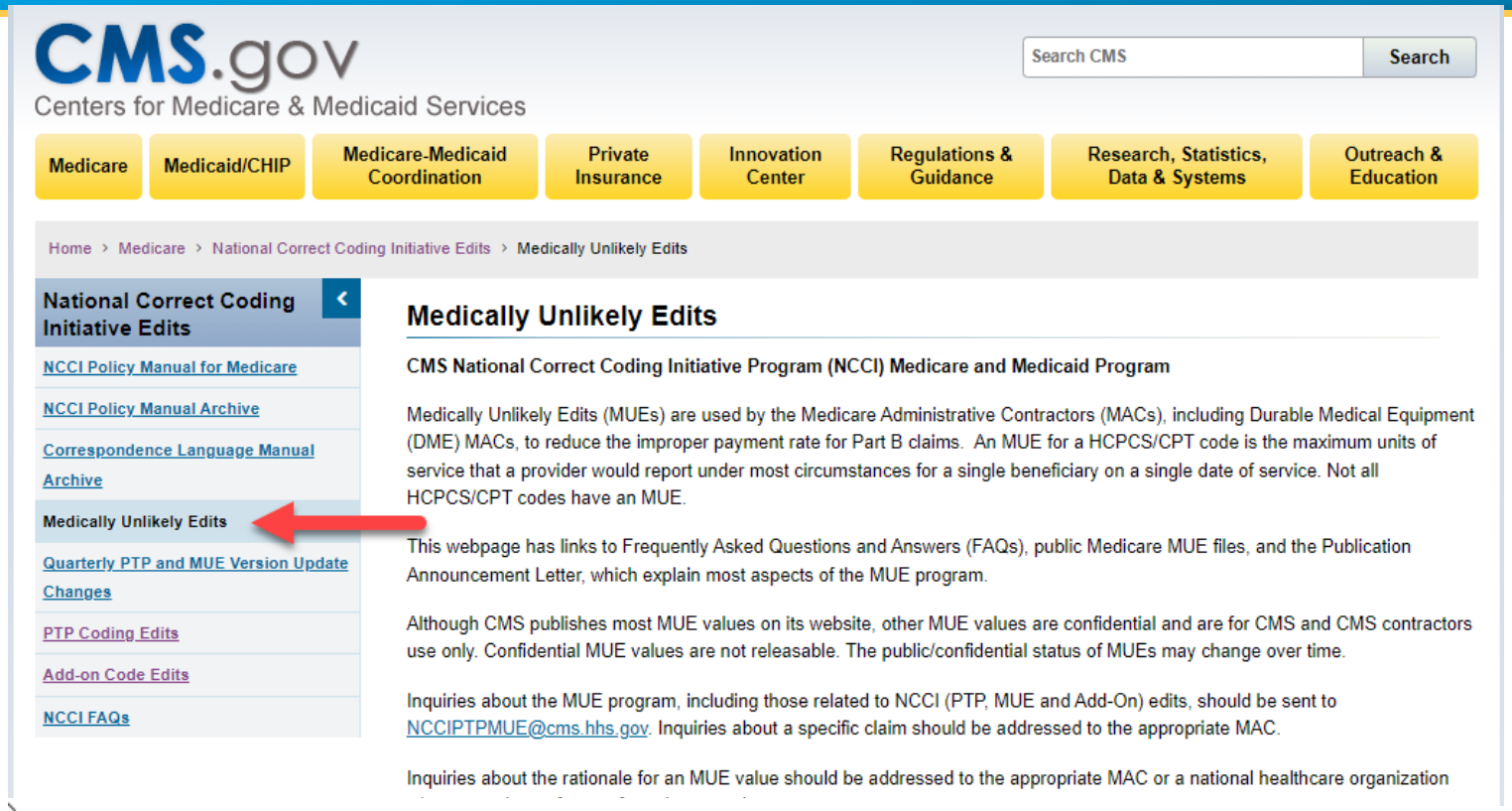
- Three provider-type choices
  - MUEs
    - Practitioner MUEs
    - DME supplier MUEs
    - Facility outpatient MUEs

MUEs

- MACs may have a unit of service edit that could be more restrictive
  - If so, that edit would be applied to the claim
- If a MUE is more restrictive than a MACs, the more restrictive edit would apply
- MUE values are not utilization guidelines
- MUEs reported less than or equal to a value for a code may still be subjected to medical review

Remittance Example and References

Code	Description
CO-16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Additional information is supplied using remittance advice remarks codes.
Reason Code 151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
Remark Code N362	Number of days/units exceed maximum.


CMS.gov
Centers for Medicare & Medicaid Services
Search CMS
Search
Medicare
Medicaid/CHIP
Medicare-Medicaid Coordination
Private Insurance
Innovation Center
Regulations & Guidance
Research, Statistics, Data & Systems
Outreach & Education
Home › Medicare › National Correct Coding Initiative Edits › Medically Unlikely Edits
National Correct Coding Initiative Edits
NCCI Policy Manual for Medicare
NCCI Policy Manual Archive
Correspondence Language Manual Archive
Medically Unlikely Edits
Quarterly PTP and MUE Version Update Changes
PTP Coding Edits
Add-on Code Edits
NCCI FAQs
Medically Unlikely Edits
CMS National Correct Coding Initiative Program (NCCI) Medicare and Medicaid Program
Medically Unlikely Edits (MUEs) are used by the Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, to reduce the improper payment rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT codes have an MUE.
This webpage has links to Frequently Asked Questions and Answers (FAQs), public Medicare MUE files, and the Publication Announcement Letter, which explain most aspects of the MUE program.
Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS contractors use only. Confidential MUE values are not releasable. The public/confidential status of MUEs may change over time.
Inquiries about the MUE program, including those related to NCCI (PTP, MUE and Add-On) edits, should be sent to NCCIPTPMUE@cms.hhs.gov. Inquiries about a specific claim should be addressed to the appropriate MAC.
Inquiries about the rationale for an MUE value should be addressed to the appropriate MAC or a national healthcare organization
Downloads
DME Supplier Services MUE Table - Effective-04-01-2022 - Posted March 1, 2022 (ZIP)
Practitioner Services MUE Table - Effective-04-01-2022 - Posted March 1, 2022 (ZIP)
Facility Outpatient Hospital Services MUE Table - Effective-04-01-2022 - Posted March 1, 2022 (ZIP)
DME Supplier Services MUE Table - Effective-01-01-2022 - Posted December 15, 2021 (ZIP)
Practitioner Services MUE Table - Effective-01-01-2022 - Posted December 15, 2021 (ZIP)
Facility Outpatient Hospital Services MUE Table - Effective-01-01-2022 - Posted December 15, 2021 (ZIP)

MUE Table

HCPCS/ CPT Code	Practitioner Services MUE Values		MUE Rationale
92700	1	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
92920	3	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
92921	6	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
92924	2	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
92925	6	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
92928	3	3 Date of Service Edit: Clinical	Clinical: Data
92929	6	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction

MUE Adjudication Indicator “1”

- This is a **claim line** edit which will deny when units of service are in excess of the MUE, although this may be impacted by the presence of a modifier on the claim line

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
J7190	22000	1 Line Edit	Clinical: Data
J7191	0	3 Date of Service Edit: Clinical	Drug discontinued
J7192	22000	1 Line Edit	Clinical: Data
J7193	4000	1 Line Edit	Clinical: Data
J7194	9000	1 Line Edit	Clinical: CMS Workgroup
J7195	6000	1 Line Edit	Clinical: CMS Workgroup

National Government Services

NGS MU

MUE Adjudication Indicator "1" Example

- J7193 Example Total of 4100 units
  - Line 1 = J7193 (MAI 1) – 4000 (MUE is 4000)
  - Line 2 = J7193 76 modifier (MAI 1) – 100 units

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
J7190	22000	1 Line Edit	Clinical: Data
J7191	0	3 Date of Service Edit: Clinical	Drug discontinued
J7192	22000	1 Line Edit	Clinical: Data
J7193	4000	1 Line Edit	Clinical: Data

National Government Services

NGS MU

MUE Adjudication Indicator “2”

- This is an absolute date of service edit. UOS in excess of the MUE value would be considered impossible because of a statute, regulation or sub regulatory guidance. This includes correct coding policy that is binding for both providers and MACs.
  - **Note:** When billing for bilateral services and the MAI value is 2, you must bill as a single line item with the 50 modifier

MUE Adjudication Indicator “2” Example

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
G0435	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
G0438	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
G0439	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
G0442	1	2 Date of Service Edit: Policy	CMS Policy
G0443	1	2 Date of Service Edit: Policy	CMS Policy
G0444	1	2 Date of Service Edit: Policy	CMS Policy
G0445	1	2 Date of Service Edit: Policy	CMS Policy

National Government Services

NGS MU

MUE Adjudication Indicator “3”

- This is a date of service edit based on clinical benchmarks. If medical necessity for the excess UOS is established through prepayment review of the claim, reopening or redetermination process or through instructions from a higher level of appeal, MACs may bypass these edits and allow the excess UOS.
  - **Note:** UOS are counted for all lines of service on the current claim and any prior finalized claim for the same DOS. When that count exceeds the MUE UOS, all claim lines for the code on the current claim are denied, although prior paid and finalized claims are not adjusted. The claim will have to be submitted through a redetermination with medical documentation to support the units of service.

MUE Adjudication Indicator “3” Example

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
82943	1	3 Date of Service Edit: Clinical	Nature of Analyte
82945	4	3 Date of Service Edit: Clinical	Clinical: Data
82946	1	2 Date of Service Edit: Policy	Nature of Service/Procedure
82947	5	3 Date of Service Edit: Clinical	Clinical: Data

National Government Services

NGS MU

MUE Adjudication Indicator “3” Example

- 82947 example of seven units (MUE 5)
- Line One – 82947 seven units (Must appeal all units)
- Claim must be appealed with documentation to support additional units in excess of five because it is a DOS edit, which means the system will add up all units for that date regardless of how many claims were submitted

MUE Notes

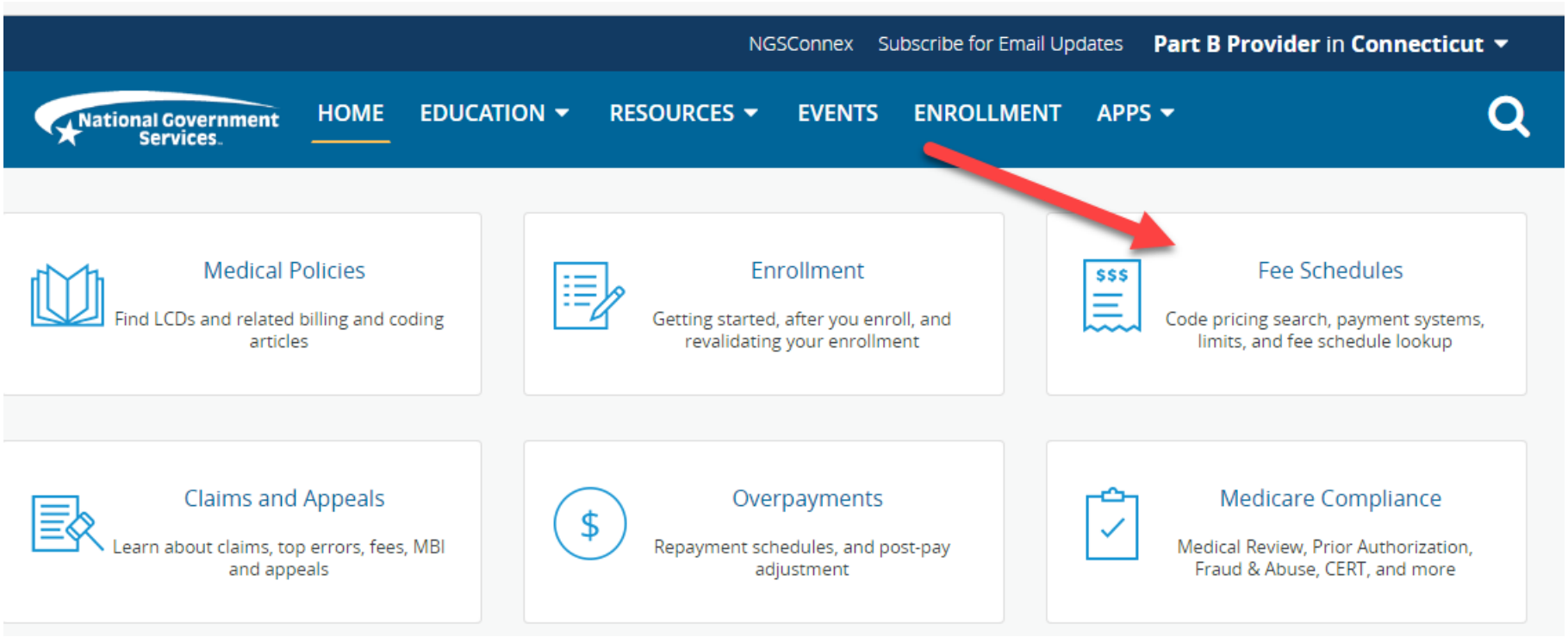
- MUE denials may be appealed
  - Denials based on coding/billing errors can be addressed via the redetermination process
- MUEs are applicable to the time period in table
- Liability cannot be shifted to the beneficiary
  - ABN issuance in anticipation of a MUE denial is not appropriate

MUE Notes

- ASCs
  - Cannot use modifier 50
    - Bill two UOS on one detail line or
    - Bill separate details using RT/LT modifiers
  - Report procedures with differing modifiers on individual claim lines when appropriate
  - Many MUEs are based on the assumption that correct modifiers are used

Modifier 50

- Used to report bilateral procedures performed at the same operative sessions as a single line item
  - Do not use modifiers RT/LT when modifier 50 is used
- Applies to any bilateral procedures performed on both sides at the same operative session
- Do not use to report on surgical procedures identified by their terminology as “unilateral or bilateral”
- Report one unit when modifier 50 is reported
- Report anatomic modifiers on individual claim lines

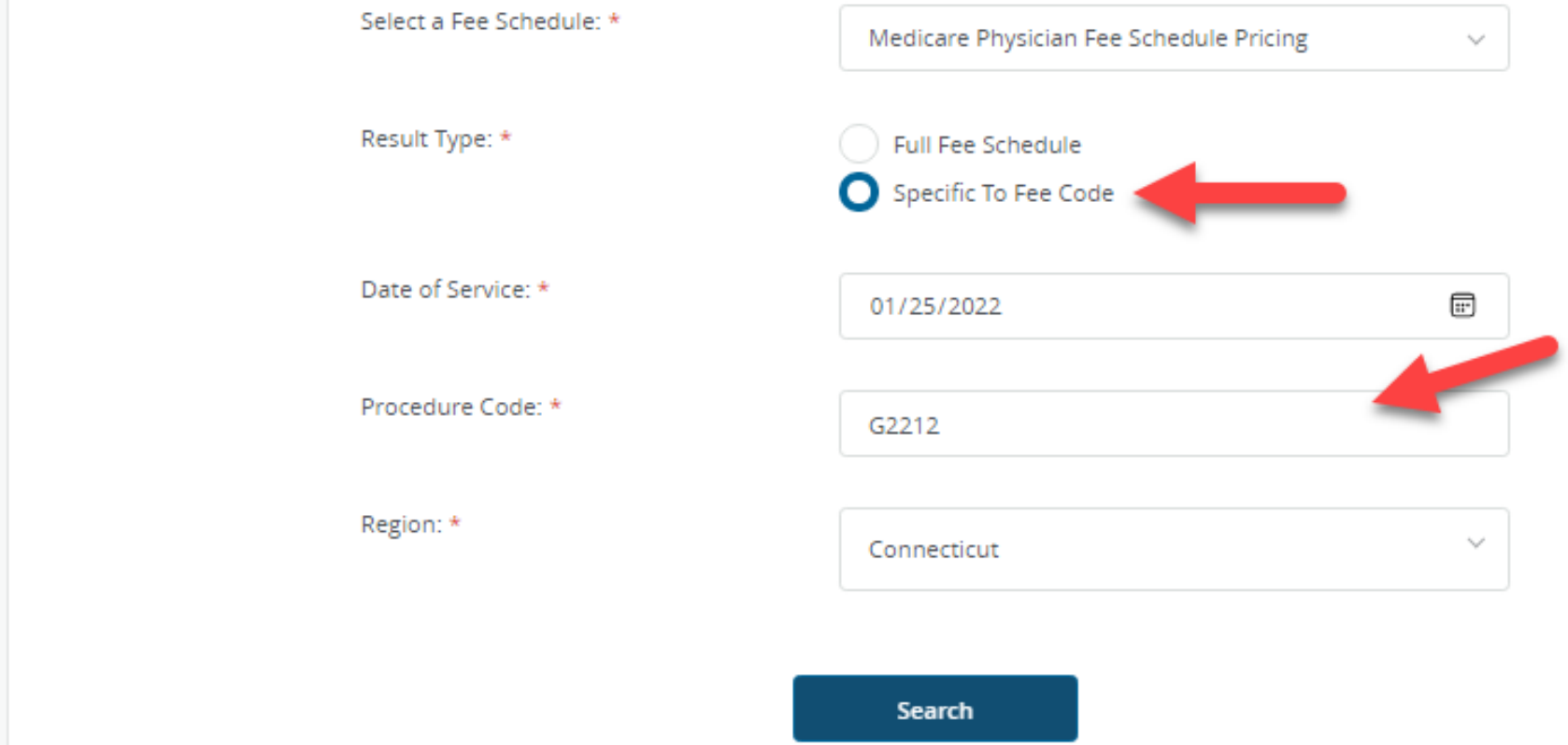


National Government Services

NGS MU

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.



Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	34.05	32.35	37.20	32.93	31.28	35.97

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	33.5983	0.9990	0.61	0.27	0.30

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.05	1.037	1.114	0.934	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	1	0	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
0	0	0	0	0

Bilateral Surgery Indicators

- **Bilateral surgery indicators**
- “0” indicates a unilateral code
  - Modifier 50 is not billable
- “1” indicates modifier 50 can be appropriate
- “2” indicates a bilateral code
  - Modifier 50 is not billable

Bilateral Surgery Indicators

- “3” indicates primary radiology codes
  - Modifier 50 is billable
- “9” indicates that the concept does not apply
- Modifier 50 cannot be appended when bilateral indicators are 0, 2 or 9

Bilateral Indicators

- Column 8: Bilateral Surgery (Modifier 50)
  - Indicates services subject to a payment adjustment

Indicator	Description
0	150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for single code. **Example:** The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100. Payment should be based on the fee schedule amount of $125 since its lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	150 percent payment adjustment for bilateral procedure applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of (a) the total actual charge for both sides, or (b), 150 percent of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

Bilateral Indicators

Indicator	Description
2	150 percent payment adjustment for bilateral does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides, or (b) 100 percent of the fee schedule for a single code**. Example:** The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100 Payment should be based on the fee schedule amount ($125) since its lower than the total actual charges for the left and right sides ($200).The RVUs are based on the bilateral procedure because (a) the code descriptor specifically states the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or © the procedure is usually performed as a bilateral procedure.
3	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9	Concept does not apply.

NCCI Contractor

- National Correct Coding Initiative Contractor
  P.O. Box 246
  Pittsford, NY 14534
- Email: NCCIPTPMUE@cms.hhs.gov
- Fax #: 1 (585) 510-7234
  - Inquiries about the NCCI program, including those related to NCCI (PTP, MUE and Add-On) edits, should be sent to the following email address: NCCIPTPMUE@cms.hhs.gov
- National Correct Coding Initiative Edits

National Government Services

NGS MU

Redetermination/Reopening

Redetermination

- Redetermination – First level of an appeal
  - Written
  - NGSConnex
- No minimum amount in controversy
- Remittance advice code
  - MA01 – Claim has appeal rights
- Attach supportive medical documentation

Reopening

- Correction to minor, uncomplicated, provider or contractor clerical errors or omissions
  - Telephone
    - TRU line will not process MUE denials
  - Written
  - NGSConnex

Reopening To correct a claim(s) determination resulting from minor errors	Redetermination (Appeal – First level) For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
• Mathematical or computational mistake • Inaccurate data entry • Computer errors • Incorrect data items • Transposed procedure or diagnostic codes	• Coverage of furnished items and service • Overpayment determinations • Medical necessity claim denials • Determination on limitation of liability provision

***Reminder:** TRU line does not accept MUE denials, they must be submitted via NGSConnex portal

Reopening

- Assignment of claims (MAC errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician
- Add/change rendering provider
- POS changes
- Duplicate denials

Reopening

- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Fee schedule incorrect
- HIC/MBI corrections (MAC error only)
- MSP – Medicare now primary
  - **Note:** MSP claims can only be processed within one year from the date of denial or payment

Reopening

- Patient paid amount (MAC error only)

Exception: If Medicaid or another government entity paid in error, please submit a written request

Modifier Appeals

- Adding/changing a modifier
  - Excluding modifiers AQ, AR, QU, QB, 22, 23, 52, 53, 62, 66, GA, GY and GZ
- Reopenings for Minor Errors and Omissions

Contacting Telephone Reopening Unit

- Please provide
  - Beneficiary's name
  - Medicare number
  - Your name and phone number
  - Provider's full name/PTAN
  - Item or service in question
  - Date(s) of service in question
  - Reason for request

NGSConnex

- Free, secure, web-based application
  - Submit claims
  - Obtain beneficiary eligibility information
  - Submit documents for ADR requests (including Medical Review)
  - Initiate and check status of redetermination and reopening requests
  - View duplicate/claim overlaps

Resources

- MLN® Booklet *How to Use the Medicare National Correct Coding Initiative (NCCI) Tools*
- Medicare Topics
  - Repeat Procedures - Modifiers 76 and 77
- MLN® Fact Sheet
  - *Proper Use of Modifiers 59 & –X{EPSU}*
- MLN Matters® *MM11168 Revised: Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes*
- CMS Medically Unlikely Edits
- NGS Medically Unlikely Edits

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

FOLLOW US

National Government Services

NGS MU