MEDDATA SERVICE BUREAU | MEDTRON SOFTWARE INTELLIGENCE

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NATIONAL CORRECT CODING INITIATIVE (NCCI/CCI) & MEDICALLY UNLIKELY EDITS (MUE)

QUARTERLY UPDATES VERSION 28.1 -- EFFECTIVE 04/01/2022

Refer to **User Guide: National Correct Coding Initiative (NCCI)**

The Centers for Medicare & Medicaid Services (CMS), developed the National Correct Coding Initiative (NCC/CCI) Procedure to Procedure (PTP) edits and Medically Unlikely Edits/Mutually Exclusive Code Edits (MUE) to encourage correct coding methodologies and to regulate improper coding that leads to inappropriate payment for Part B claims. CMS owns the NCCI program and is responsible for all decisions regarding its contents. The tables are **updated quarterly** and loaded into the Medicare claims payment processing systems and onto the CMS NCCI webpage.

CMS develops these 'bundling' coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent using an inappropriate code combination.

Procedure to Procedure (PTP) edits:
PTP edits are automated prepayment edits to prevent inappropriate payment of services that should not be reported together. PTP code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Center (ASCs).

Each PTP edit has a Column One and Column Two HCPCS/CPT code. A Column Two code is often a component of a more comprehensive Column One code. If a provider reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported (see next page for valid list of modifiers).

In the modifier indicator column of the PTP edit table, the modifier indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

- 0 (Not Allowed) → There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
- 1 (Allowed) → The modifiers associated with NCCI are allowed with this PTP code pair **when appropriate**.
- 9 (Not Applicable) → This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactive to the implementation date.

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
77427	96159		20201001	*	0	Standards of medical / surgical practice
77427	96159		20200101	20200101	9	Standards of medical / surgical practice
77427	96160		20201001	*	1	CPT Manual or CMS manual coding instructions
77427	96160		20170101	20191231	1	CPT Manual or CMS manual coding instructions
77427	96161		20201001	*	1	CPT Manual or CMS manual coding instructions
77427	96161		20170101	20191231	1	CPT Manual or CMS manual coding instructions
77427	96164		20201001	*	0	Standards of medical / surgical practice
77427	96164		20200101	20200101	9	Standards of medical / surgical practice
77427	96165		20201001	*	0	Standards of medical / surgical practice
77427	96165		20200101	20200101	9	Standards of medical / surgical practice
77427	96167		20201001	*	0	Standards of medical / surgical practice
77427	96167		20200101	20200101	9	Standards of medical / surgical practice

Mutually Exclusive Coding:
Many procedure codes should **not** be reported together because they are mutually exclusive of each other.
Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same beneficiary encounter.

Examples of a mutually exclusive scenarios:
- Repair of an organ that can be performed by different methods, only one method can be chosen, i.e., vaginal hysterectomy, total abdominal hysterectomy, laparoscopic hysterectomy.
- A service that can be reported as an initial service **or** a subsequent service, i.e., new patient visit and established patient visit or initial hospital visit and subsequent hospital visit.

Medically Unlikely Edits (MUE):
MUEs are developed based on HCPCS/CPT code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyte, nature of equipment, prescribing information, and clinical judgment.

A MUE for a HCPCS/CPT code is **the maximum number of units** of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service. MUEs prevent payment for an inappropriate number/quantity of the same service on a single day, however not all CPT/HCPCS codes have a published MUE value.

MUE values are not utilization guidelines. Providers should continue to only report services that are medically reasonable and necessary. Providers may be subject to medical review of their claims even if they report UOS less than or equal to the MUE value for a code.

NOTE: Most MUEs are visible to providers on the CMS NCCI webpage.
However, some MUEs are considered confidential by CMS and are not released.
The public/confidential status of MUEs may change.

The MUE Adjudication Indicator (MAI) determines how the MUE edits will process in the MACs system.
MUEs for codes with a MAI of:
1 – Claim line edit. Service lines can be split and an appropriate modifier, i.e., 76, XE, XS, XP, XU, (59*) can be applied to the separate line item.
2 – Absolute date of service edits, i.e., "per day edits based on policy". CMS gives no instances in which a higher unit value would be correct and payable, i.e., no appeal rights.
3 – Date of service edits. Additional units are considered via appeal if there is adequate documentation of medical necessity to support reported units.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator (MAI)	MUE Rationale
11981	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
21267	1	2 Date of Service Edit: Policy	CMS Policy
43763	2	3 Date of Service Edit: Clinical	Clinical: Society Comment
71045	4	3 Date of Service Edit: Clinical	Clinical: Data
78832	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
80061	1	3 Date of Service Edit: Clinical	Nature of Analyte
88305	16	3 Date of Service Edit: Clinical	Clinical: Data
0630T	4	2 Date of Service Edit: Policy	Anatomic Consideration
A0425	250	1 Line Edit	Clinical: Data
A6460	1	1 Line Edit	Clinical: CMS Workgroup
G0400	1	2 Date of Service Edit: Policy	Nature of Service/Procedure
J3471	999	1 Line Edit	Code Descriptor / CPT Instruction
J7175	9000	1 Line Edit	Prescribing Information

MSI updated the 'Charge Record' Limit Frequency/DOS field to display only the **CMS** MUE and show the associated MAI.
Corresponding **MED**PM Charge Entry and Unprocessed Report messages were enhanced:
Old message: "*NOTE: Number of Units Exceeds Medicare's Medical Unlikely Edit."
New messages:
QTY > ____ Medicare's MUE MAI1 Excess bill on separate line w/MOD
QTY > ____ Medicare's MUE MAI2 Absolute DOS Limit NO APPEAL
QTY > ____ Medicare's MUE MAI3 All on same line can APPEAL.
NOTE: Blanks are completed based on 'Limit Freq' field in Charge Record of the Transaction Master.

NOTE: Not all carriers use CMS MUEs, some have their own frequency list, i.e., LA Medicaid (see link under resources below, also column 13: UVS>001 on fee schedule for codes allowed more than once per day), these values may be added to the charge record via the Transaction Master.

Modifiers:
Modifiers are applied to HCPCS/CPT codes only if the clinical circumstances justify using the modifier. A modifier should **not be appended** to a HCPCS/CPT code **solely to bypass** a MUE or PTP code pair edit if the clinical circumstances do not justify using the modifier. If the Medicare Program imposes restrictions on applying a modifier, the modifier may only be used to bypass a PTP code pair or MUE edit if the Medicare restrictions are fulfilled.

ⓘCorrect Coding Modifiers (CCM) are used to address modifier flag '1' scenarios, i.e., Anatomical modifiers are used in NCC modifier flag '1' scenarios; see NCCI Policy Manual for more information on CCMⓘ modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:
- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
  - NOTE: Modifiers 24, 25 and 57 are only ever affixed to Evaluation & Management (E&M) CPT codes (99202-99499).
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

REMINDERS:

- Column 1 codes are the Comprehensive codes and Column 2 codes are the Component codes (*Component codes are included in the Column 1 Comprehensive codes).*

- Modifier indicator flag '1' associated with a pair of CPT codes allows eligible providers to bill both services for the same patient on the same day provided documentation supports medical necessity for both codes and proper use of a CCMⓘ modifier and the modifier is affixed to the **component** column 2 CPT code.
  - In 2019, CMS changed to allow modifier on either code of the pair.

- Modifier indicator flag '0' associated with a pair of CPT codes will only allow payment of one of the codes, i.e., '0' flag denotes **no modifier will bypass** the NCC edit.

RESOURCES:
CMS NCCI files are available via: https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits

CMS MUE files are available via: https://www.cms.gov/medicare/coding/nationalcorrectcodinited/mue.html

NCCI Policy Manual: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

LA Medicaid NCCI PTP Edits: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html

See prior News Blasts for previous NCCI/MUE Changes/Updates and prior Quarter score cards (available via www.medtronsoftware.com)

The following pages list the quarterly updates for the upcoming year.

Clients may request a custom file of active codes/edits; please request a quote via helpdesk@medtronsoftware.com.

For assistance or questions, contact MDS/MSI:
From MEDPM or MEDEHR sign-on screens double click on helpdesk@medtronsoftware.com to compose an email to our Support Team. You may also email helpdesk@medtronsoftware.com directly from your email server.
The email will auto-create a ticket in our Help Desk system and send you an automated reply with your ticket #.
If you need to provide further information/updates, reply to the email containing your assigned ticket # and specify any additional information. If a call is required after a ticket # is assigned, **please be prepared to provide your ticket number** to our Operators to ensure effective and proper routing of your call.

Effective April 01, 2022
Version 28.1
(per CMS' Quarterly PTP Version Update files)

PTP edits include:
4,012 new CPT code edit pairs
140 deleted CPT code pairs

MUE edits include:
15 additions
0 deletions
1 revisions

CCI version 28.1 scorecard

Changes effective April 1, 2022.

(For more on CCI version 28.1 edits, see related story, p. 4.)

Code range	CCI code pairs added	CCI code pairs deleted	MUEs added	MUEs deleted	MUEs revised
00000 — 09999	192	0	0	0	0
10000 — 19999	0	0	0	0	0
20000 — 29999	0	0	0	0	0
30000 — 39999	3	2	0	0	0
40000 — 49999	84	7	0	0	0
50000 — 59999	0	1	0	0	0
60000 — 69999	1	10	1	0	0
70000 — 79999	0	12	0	0	0
80000 — 89999	753	0	5	0	0
0001U — 0284U	2,944	0	1	0	0
90000 — 99999	7	46	5	0	0
0001T — 0999T	28	41	0	0	0
A0000 — V9999	0	21	3	0	1
Totals	**4,012**	**140**	**15**	**0**	**1**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI version 28.1 changes,* www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes

0582T - Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance:
Several codes were added as components of 0582T with a Modifier indicator: 1.

Approximately 73%, of the new code pairs include a U code (proprietary laboratory analysis) as one part of the coding bundle which are paired with a range of other pathology and laboratory codes found in the 80000 series of the CPT manual.

93593-93597 Heart catheterization procedures were assigned a MUE of 1.

Effective January 1, 2022
Version 28.0
(per CMS' Quarterly PTP Version Update files)

PTP edits include:
49,172 new CPT code edit pairs
16,024 deleted CPT code pairs

MUE edits include:
211 additions
59 deletions
7 revisions

CCI version 28.0 scorecard

Changes effective Jan. 1, 2022.*(For more on CCI version 28.0 edits, see related story, p. 4.)*

Code range	CCI code pairs added	CCI code pairs deleted	MUEs added	MUEs deleted	MUEs revised
00000 – 09999	2,590	1,762	0	0	0
10000 – 19999	188	13	0	0	0
20000 – 29999	3,082	27	0	0	2
30000 – 39999	4,498	834	8	2	1
40000 – 49999	2,238	722	2	2	0
50000 – 59999	2,554	268	3	1	1
60000 – 69999	6,228	2,147	14	7	1
70000 – 79999	1,074	61	4	3	0
80000 – 89999	4,992	1,488	18	2	0
0001U – 0284U	3,321	656	30	2	0
90000 – 99999	4,021	2,011	22	11	0
0001T – 0999T	14,040	5,992	71	25	1
A0000 – V9999	346	43	26	4	1
Totals	**49, 172**	**16,024**	**211**	**59**	**7**

Note: Code range is based on the comprehensive code of the edit.

Source: *Part B News* analysis of CCI version 28.0 changes, www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes

E&M Services

Edits for the new time-based Principal Care Management (PCM) codes (99424-99427) when performed by a physician or qualified health care professional (QHP) (99424-99425) will vary based on whether the practice bills an add-on code.

- If a provider bills 99424, which represents at least 30 minutes of PCM in a calendar month, services such as blood draws from a venous access device or PICC line (36591 or 36592), vent management (94002-94004) and remote blood pressure monitoring (99473-99474) are bundled into the E&M service.
- If the provider performs at least 60 minutes of PCM, which would be reported with 99424 and one unit of add-on code 99425 (30 additional minutes), the list of bundled services **expands** to include services such as end-stage renal disease services (90960-90970) and online E&M services (99421-99423).

The edit pairs for PCM performed by supervised clinical staff (99426-99427) mirror the edits for 99424 up to a point, but the list of pairs is roughly four times longer and does not contain much variance for the primary and add-on code.
Most E&M visits are bundled into the clinical staff service.

Anesthesia Care

The six new 2022 anesthesia (ASA) codes for percutaneous image guided spine procedures (01937-01942) will receive the same edit pairs of the anesthesia for diagnostic and therapeutic service codes (01935-01936) that they replaced. Services such as needle placement (36000-36015), nerve blocks (62320-62327 and 64400-64493) and E&M office/outpatient visits (99202-99215) will also be bundled into the six new anesthesia codes.

Cardiovascular System

A wide range of services is paired with the trio of new 2022 codes for exclusion of the left atrial appendage (33267-33269) and the two new codes for endovascular stent repair (33894-33895). Services bundled into the cardiovascular codes include skin debridement (11000-11006), electrocardiograms (93000-93010) and observation and hospital inpatient visits (99217-99239).

The exclusion codes (33261-33269) have a MUE of 1 and a modifier adjudication indicator (MAI) of 2, indicating denials for additional services can't be appealed. The endovascular stent repair codes (33894-33895) have a MUE of 1 and a MAI of 3, therefore practices that perform additional units of service can appeal denials.

Digestive System

In addition to many of the codes bundled into the new 2022 cardiovascular codes, 43497 (Lower esophageal myotomy, transoral (i.e., peroral endoscopic myotomy [POEM]) **includes anesthesia** for upper and lower gastrointestinal endoscopy procedures (00731-00732 and 00811-00813) and esophagoscopy codes, such as 43191 and 43200. POEM has a MUE of 1 and a MAI of 2, therefore denials for additional units cannot be appealed.

Urinary System

The new 2022 periurethral adjustable balloon continence device codes (53451-53454) are carrier-priced. Therefore, codes that are bundled into the service, which range from debridement codes to a wide range of E&M visits, will not be paid. CMS assigned a MUE of 1 and a MAI of 2 to 53451, therefore denials for additional units of service can't be appealed. However, 53454 has a MUE of 1 and a MAI of 3, therefore practices can appeal denials of additional units of service.

Nervous System

Practices will receive denials when they report services such as needle electromyography (95860-95870), nerve conduction studies (95907-95913) and somatosensory testing (95925-95927) with laser interstitial thermal therapy (LITT), an intercranial procedure (61736-61737). The codes are bundled into the LITT service and can't be unbundled. Both services have a MUE of 1 and a MAI of 2, therefore denials for additional units cannot be appealed.

The two new 2022 add-on codes for lumbar arthrodesis decompression (63052-63053) will include services such as bone biopsy (20251), insertion of spinal stabilization/distraction devices and lumbar spinal decompression (63056) and fluoroscopic guidance (77001-77003). The single lumbar body decompression code (63052) has a MUE of 1, and the code for each additional vertebral body (63053) has a MUE of 4. Both codes have a MAI of 2, therefore denials for additional units cannot be appealed.

Radiology

The four new 2022 codes for trabecular bone score (77089-77092) an imaging service used to evaluate osteoporosis received a small set of **unbreakable edit pairs** that include blood drawn from a venous device or a PICC line (36591 or 36592) and irrigation of a drug delivery device. The code for an image and an interpretation and report of the patient's fracture risk (77089) has a MUE of 1 and a MAI of 2, therefore denials for additional units cannot be appealed.

The remaining codes, which describe technical work (77090-77091) and an interpretation and report by a physician or QHP (77092), also have a MUE of 1 and a MAI of 3, therefore practices can appeal denials of additional units of service.

Medicine

The new 2022 cardiac catherization codes for congenital defects of the right heart (93593-93594), left heart (93595) and right and left heart (93596-93597) plus the new 2022 companion add-on code (93598) will include services such as blood vessel repair (35201-35286) and exhaled air analysis (94680-94681). CMS did not assign MUEs to the primary codes, but the add-on code received a MUE of 1 and a MAI of 2, therefore denials for additional units cannot be appealed.

Practices that have been reporting outpatient pulmonary rehabilitation code (G0424) should take note of the new edits associated with the two new 2022 codes that will replace G0424 (94625-94626). Services that are bundled into the codes include electrocardiograms (93000-93010) cardiovascular stress tests (93015-93018) and physical therapy and occupational therapy evaluation services (97161-97164 and 97165-97168).