**Medicaid National Correct Coding Initiative
Technical Guidance Manual**

**(Includes material previously published in the Medicaid NCCI
Edit Design Manual)**

Revised 01/01/2020

Contents

Revision Date (Medicaid): 01/01/2020

1

Revision Date (Medicaid): 01/01/2020

Revision Date (Medicaid): 01/01/2020

Revision Date (Medicaid): 01/01/2020

4

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

The Medicaid National Correct Coding Initiative (NCCI) webpage on the Medicaid.gov website at: https://www.medicaid.gov/medicaid/program-integrity/NCCI/index.html provides:

- basic information on the Centers for Medicare & Medicaid Services (CMS) NCCI in the Medicaid program;

- reference documents on the Medicaid NCCI program; and

- 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 National Correct Coding Initiative Policy Manual for Medicaid Services provides technical coding information that state Medicaid agencies, fiscal agents, and providers may use to understand the basis of specific NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs).

- The Medicaid National Correct Coding Initiative Technical Guidance Manual provides information for state Medicaid agencies and fiscal agents about NCCI policies. It also includes the information that was previously published in the Medicaid National Correct Coding Initiative 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 National Correct Coding Initiative Correspondence Language Manual for Medicaid Services provides information that state Medicaid agencies and fiscal agents can use to respond to inquiries from providers concerning specific Medicaid NCCI PTP edits and MUEs.

Revision Date (Medicaid): 01/01/2020

Medicaid NCCI information and edit files for states are provided through a partnership with the Medicaid Integrity Institute (MII) 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 Medicaid National Correct Coding Initiative Methodologies

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

- all six national Medicaid NCCI methodologies unchanged;[1]

- all four 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 on the claim line or claim;

---

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

[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 states 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 MII on the RISSNET portal. States cannot use the Medicaid NCCI files posted on the Medicaid NCCI webpage on the Medicaid.gov website.

Revision Date (Medicaid): 01/01/2020

- the claim-adjudication rules in the Medicaid NCCI methodologies;[4] and

- all modifiers for Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes needed for the correct adjudication of applicable Medicaid claims.[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.

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

---

[4] Section 6507 of the Affordable Care Act made the Medicaid NCCI methodologies primary in state processing of Medicaid claims. This means that the claim-adjudication rules in the Medicaid NCCI methodologies should be applied prior to application of state PTP edits and 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.

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 appeals 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 Reference Documents section of the NCCI Medicaid website.

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

Revision Date (Medicaid): 01/01/2020

compliant with all federal requirements for state implementation of the NCCI methodologies.[8]

4.0 Enhanced Federal Financial Participation for Medicaid Management Information Systems

Section 1903(r) of the Social Security Act (SSA), as amended by section 6507 of the Affordable Care Act (ACA), describes the functionality of a state's 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

---

[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:

- 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).

Revision Date (Medicaid): 01/01/2020

5.1 Types of Medicaid Claims to which the Medicaid 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 a FFS basis in state Medicaid Primary Care Case Management managed care programs. Application of NCCI methodologies to FFS claims processed by limited benefit plans or Managed Care Organizations is desirable but optional.

Concerning Medicare crossover claims[10]:

- Paid claim lines on crossover claims processed by the A/B MACs and 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 new Medicaid claims.
- MACs have already applied Medicare NCCI edits to most claims. It is **optional** for the states to apply Medicaid DME PTP edits to DME crossover claims from the MACs. The Medicare DME MACs do not currently apply DME PTP 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.

---

[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 Medicare Administrative Contractors (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.

Revision Date (Medicaid): 01/01/2020

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

The Medicaid NCCI methodologies are **not applicable** to four 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; and

- Medicaid claims from inpatient and residential facilities, e.g., services to inpatients provided by hospitals and services to residents provided by nursing homes.

5.3 Types of Providers Whose Claims Must Be Subjected to Application of the Medicaid NCCI Methodologies[12]

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

---

[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, one of the four components of the Medicaid NCCI methodologies.

Revision Date (Medicaid): 01/01/2020

11

laboratories, and radiology departments, and other
diagnostic and therapeutic services); and

- providers of durable and home medical equipment.

5.4 Managed Care[13]

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

Table 1: **Application of the Medicaid NCCI Methodologies to Three
Principal Types of Medicaid Managed Care**

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

---

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

Revision Date (Medicaid): 01/01/2020

5.4.1 Primary Care Case Management

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

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

5.4.2 Managed Care Organizations

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

- apply the Medicaid NCCI methodologies to the encounter data from the MCO, if it wishes to do so and if the encounter data 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 a FFS basis, or if an MCO that pays claims on a FFS basis chooses to use the Medicaid NCCI methodologies, even

Revision Date (Medicaid): 01/01/2020

13

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

The table below 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.

Revision Date (Medicaid): 01/01/2020

14

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

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

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

Provider type	Mandatory / Optional	CMS 1500 or 837P Claim form or equivalent; Rendering Practitioner identified	CMS 1500 or 837P Claim Form or Equivalent; Rendering Practitioner 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

---

[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 practitioner and ambulatory surgical center (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.

Revision Date (Medicaid): 01/01/2020

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

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 two 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 durable medical equipment; 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.

---

[19] NCCI Durable Medical Equipment 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 three PTP edit files and the three 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.

Revision Date (Medicaid): 01/01/2020

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 Medicaid Integrity Institute (MII) using a secure portal (RISSNET). The publicly available files located on the Medicaid NCCI 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.gov website at: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

7.1.2. Final Quarterly Edit Files

States must download the NCCI edit files that are available on the Medicaid Integrity Institute (MII) using a secure portal (RISSNET). The publicly available files located on the Medicaid NCCI webpage are not for use by states.

All PTP edits contained in the final quarterly Medicaid NCCI edit files for states (obtained on the MII using the RISSNET portal are also contained in the Medicaid NCCI edit files for the current calendar quarter which is posted on the Medicaid NCCI page on the Medicaid.gov website.

The final quarterly Medicaid NCCI MUE files posted for states on the MII 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 Medicaid NCCI 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 website at:

https://www.CMS.gov/medicare/coding/nationalcorrectcodinited/mue.html

Table 3: Differences in the Fields in the Medicaid NCCI Edit Files Posted on the Medicaid NCCI Webpage on the Medicaid.gov

Revision Date (Medicaid): 01/01/2020

17

Website and on the Medicaid Integrity Institute (MII) 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[24] before the beginning of a new calendar quarter, CMS posts the final, complete, quarterly Medicaid NCCI files on the MII. The state is required to implement the edits in those files beginning with claims processed on the first day of the calendar quarter. If the state has not implemented the edits in those files by the beginning of the second month of the calendar quarter using the new quarterly edit files, it must reprocess claims that were processed from the first day of the calendar quarter to the day that the edits from the new files were first applied. For example, if the edits in the January 2014 edit files were not implemented until February 7, 2014, the state must reprocess claims that were previously processed from 1.1.14 through 2.6.14.

A state Medicaid agency must use the most recent final quarterly Medicaid NCCI files that have been posted on the MII 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 2014 for claims that are processed and paid from 1.1.14 through 3.31.14, regardless of the date of service on the claim.

If a state's MES is processing a Medicaid claim with a date of service 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 MII, not with the Medicaid NCCI edit files for the earlier calendar quarter.

---

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

[24] Prior to August 2015, the final edit files were posted to the MII 15 days before the beginning of a new calendar quarter.

Revision Date (Medicaid): 01/01/2020

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

Every quarterly Medicaid NCCI edit file contains a version date, which is the first day of the calendar quarter 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 date of service of the claim. For example, the version date for the edits contained in the state Medicaid NCCI edit files for the second quarter of 2014 is April 1, 2014. These edits must be applied to claims that are processed by a state between April 1, 2014, and June 30, 2014.[25]

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 date of service on the claim line and only apply the Medicaid NCCI edit if the date of service is on or after the effective date of the edit and on or before the deletion date of the edit (if applicable).

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

---

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

Revision Date (Medicaid): 01/01/2020

Revised: 01/01/2020

contained in the Medicaid NCCI edit files with a version date of 1.1.14 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 MII. COTS vendors do not have direct access to this website or to these files. States are notified of all Medicaid NCCI information and edit files through the secure portal on the **MII site**

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

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

A state Medicaid agency may share these quarterly state Medicaid NCCI edit files which are posted on the MII on the RISSNET portal with the contracted fiscal agent that processes its fee-for service claims or with any of its contracted Medicaid managed-care entities that is 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.

Revision Date (Medicaid): 01/01/2020

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 webpage at the beginning of each calendar quarter may not be released prior to this time.

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.

7.1.2 Confidentiality Agreements Requirements for Contracted Parties

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 MII:

- Disclosure shall be limited to only those responsible for the implementation of the quarterly state Medicaid NCCI edit files. Disclosure shall not be made prior to the start of the new calendar quarter.

- 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 Medicaid NCCI 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 Medicaid NCCI webpage.

Revision Date (Medicaid): 01/01/2020

- 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 MII.

- State Medicaid agencies must impose penalties, up to and including loss of contract, for violations of any confidentiality agreement relating to use of the MII edit files.

7.1.3 Medicaid-only NCCI Edits

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

Once each quarter, CMS will post files with proposed Medicaid-only NCCI edits to the Medicaid Integrity Institute (MII) on the RISSNET portal. States will be notified of Medicaid NCCI information and edit files through the secure portal on the MII site. The target date for implementation of the edits will be two quarters later. For example, the target implementation for edits that are proposed in January will be the July quarterly update. (These files do not contain proposed Medicare NCCI edits that will be included in the final Medicaid NCCI edit files for that calendar quarter.)

The proposed edits and the accompanying cover memo contain confidential information that must not be shared with anyone other than a Contracted Party. If a state shares the edits with a Contracted Party, the following restrictions apply: Prior to their effective date, the edits must not be published, the edits must not be used by any reviewer for non-Medicaid purposes, and the edits must not be implemented by state Medicaid agencies. The state must not publish an article related to these edits

Revision Date (Medicaid): 01/01/2020

22

because significant changes, including changes in the implementation date, could be made prior to implementation.

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

    MCD_State_Comment_Process_PTP_mm-dd-yyyy.xlsx
    MCD_State_Comment_Process_MUE_mm-dd-yyyy.xlsx

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

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

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

- Format (a) lists every edit individually and contains the following columns:

    o Column 1 HCPCS/CPT Code
    o Column 1 Code Descriptor
    o Column 2 HCPCS/CPT Code
    o Column 2 Code Descriptor
    o Correct Coding Modifier Indicator (CCMI) Value
    o Edit Rationale

- Format (b) has a list of Column 1 and Column 2 codes and their descriptors with the explanation that each Column 1 code is paired with each Column 2 code. The CCMI values and edit rationales that apply to all the edits for a particular Column 2 code are listed in the columns related to that Column 2 code.

- Format (c) has a list of HCPCS/CPT codes and their descriptors with the explanation that each code is paired with every code below it in the list. The code that is higher in the list will be Column 1 code and the codes that are lower in the list will be the Column 2 codes.

Revision Date (Medicaid): 01/01/2020

The CCMI values and rationales that apply to all the edits for a particular Column 1 code are listed in the columns related to that Column 1 code.

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

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

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

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

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

The MUE Value column in each MUE file identifies in which edit set(s) the edit will be included – PRA, OPH, or DME. For example, an entry of 1/1/NA (NA = not applicable) indicates that the edit will be included in the PRA and OPH edit sets with an MUE value of "1," but will not be included in the DME edit set. If a new or revised MUE is being proposed in an edit set, but an existing MUE is being retained in another edit set, this will be

Revision Date (Medicaid): 01/01/2020

24

indicated by NC (no change). For example, an entry of NC/0/NA
indicates that the existing PRA MUE will not be changed but a
new or revised MUE of "0" is being proposed in the OPH edit set
and there is no MUE in the DME edit set.

States will have 60 days from the date of posting to review and
comment on the proposed edits. If a state disagrees with the
proposed edits, it should send its comments in writing to the
NCCI contractor, either by email, mail, or by fax. The review
of, and comment on, the proposed edits should consider the
appropriateness of the edits based on NCCI coding policies. The
comments from the state must clearly identify the edits that are
being challenged. If the state is requesting that the edit not
be established, the comments should provide an explanation for
that position. If the state thinks that the CCMI should be
different, it should explain its rationale.

The pertinent addresses and phone numbers will be included in
the cover memo that will be posted along with the proposed edit
files.

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

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

For PTP edits, if a state's claims processing system is set so
that the Column 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, in order 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

Revision Date (Medicaid): 01/01/2020

25

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 15 days before the beginning of a new calendar quarter, CMS posts the Change Reports for that quarter on both the secure MII and the Medicaid NCCI webpage. The reports posted on both websites are identical.

The fields on the PTP edit Change Reports are: Code 1, Code 2, Correct Coding Modifier Indicator (CCMI). The fields on the MUE Change Reports are: 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 MII 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 four categories of edits for processing and paying Medicaid claims:

- Medicaid NCCI PTP edits and MUEs

- State-specific screening edits

- State-specific PTP edits and units-of-service (UOS) edits which address services rendered on the same date of service

- Other state-specific edits

Revision Date (Medicaid): 01/01/2020

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

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

Examples of screening edits, screen for the following non-exclusive items:

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

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

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

Examples (not all-inclusive):

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

Units-of-service 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

Revision Date (Medicaid): 01/01/2020

27

an automated edit or an edit that suspends a claim for manual review.

Examples (not all-inclusive):

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

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

Examples (not all-inclusive):

- PTP edits addressing services provided on multiple / different dates of service, e.g., global-surgery edits and obstetrical edits addressing follow-up visits
- UOS / cutback edits addressing more than a single date of service
- Benefit-limit edits addressing more than a single date of service
- Services that require prior authorization and for which more than one UOS could be authorized and the authorization addresses more than a single date of service
- Services that require prior 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 date of service and
  - **always** result in either complete denial of payment or complete payment for the service
- Medical-necessity edits and utilization-review edits which **always** result in complete denial of payment or complete payment of the submitted UOS (e.g., diagnosis, gender, age)

Revision Date (Medicaid): 01/01/2020

28

- Medical necessity edits and utilization review edits which address services provided on more than a single date of service
- Bundling edits in which the component codes are billed, but the comprehensive code is not billed
- Edits for third-party liability
- Pricing edits – as long as the edit does not have the **potential** of reducing the allowed/paid UOS

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

If one of these edits is applied before the Medicaid NCCI edits and it results in the payment of only some of the submitted UOS, then the payable / cutback UOS 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; or
- using the state's existing Medicaid payment appeals process.

Revision Date (Medicaid): 01/01/2020

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[26]

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. 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.

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 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; and

Revision Date (Medicaid): 01/01/2020

30

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.[28]

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 MII site. States have 60 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 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 Procedure-to-Procedure Edits

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

Revision Date (Medicaid): 01/01/2020

31

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 date of service on all claim lines on all applicable Medicaid claims and apply the Medicaid PTP edits to these codes, when appropriate.

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

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

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

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

---

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

Revision Date (Medicaid): 01/01/2020

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

A state may request through the NCCI Mailbox (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:

- when the state allows separate payment for a service or item that is usually bundled into the payment for the Column One code;

- when the state requires prior authorization for payment of both codes of a PTP edit pair; and

- when the state's 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?

Revision Date (Medicaid): 01/01/2020

33

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, in order 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 Procedure-to-Procedure 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.[28] State-specific PTP edits may deny payment for codes on Medicaid claims for which a Medicaid PTP edit was bypassed due to the presence of a PTP-associated modifier. Denials of payment due to state-specific PTP edits must be clearly characterized as state-specific denials of payment, not as NCCI denials of payment.

7.6 Units-of-Service Edits and Medically Unlikely Edits

7.6.1 Units-of-Service Edits in General[29]

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

- the HCPCS or CPT code or codes covered by the edit (e.g., a single physical therapy code or multiple physical therapy codes);

---

[28] Refer to Sections 7.3 – 7.3.3 for more information on order of edits.
[29] All units-of-service edits are assumed here to apply to claim lines and claims for the same beneficiary. This includes Medically Unlikely Edits (MUEs).

Revision Date (Medicaid): 01/01/2020

- the number of claim lines the edit is applied to in each claim (e.g., a single claim line or all claim lines);

- the period of time the edit is applied to (e.g., all claims on the same DOS, all claims with a DOS in a calendar year, or all claims with a DOS in a rolling 12-month period);

- the providers the edit is applied to (e.g., the same provider, one or more categories of providers, or all providers);

- the unit of measure used by the edit (e.g., per procedure [e.g., for a surgical procedure or diagnostic test], per encounter or visit [e.g., for most evaluation-and-management codes]; or per unit of time [e.g., per 15 minutes or per day]); and

- the "value" of the edit, which is the maximum number of UOS allowed by the edit.

The claim-adjudication rule for a UOS edit specifies the number of UOS that will be paid in most circumstances for the HCPCS or CPT code, if the number of UOS billed exceeds the "value" for the UOS edit. For example, the claim-adjudication rule for a state-specific UOS edit may allow all UOS up to the "value" of the UOS edit to be paid; UOS billed above that "value" will not be paid. [30]

7.6.2 Medically Unlikely Edits

NCCI "Medically Unlikely Edits" (MUEs) are UOS edits.

A CMS NCCI MUE is defined by the following elements:

- the HCPCS or CPT code;

- a value;

---

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

- an effective date; and

- a deletion date (if applicable).

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

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

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

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

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

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

Revision Date (Medicaid): 01/01/2020

36

the code on that claim line are in addition to the UOS billed for the same code on a different claim line.[31] However, the modifier that is used must not be one of the designated PTP-associated modifiers.[32]

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 one line of a Medicaid claim is "2." If the number of UOS billed for that code on that one claim line is greater than "2," then none of the UOS billed for that code on that claim line should be paid.

7.6.2.1 Medically Unlikely Edits and Span Dates

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

For example, the provider bills a HCPCS/CPT code which has an MUE value of "1." The "From" date listed on the claim line is

---

31 See Appendix C
32 Listed in section 8.1 of this manual.

Revision Date (Medicaid): 01/01/2020

07/01/2013 and the "To" date is 07/10/2013. The "date span" of the claim line is 10 days. If the UOS billed on the claim line are "14," those UOS should be divided by the number of days in the date span (10) to determine the number of UOS billed "per day." In this example, the "per day" UOS equal "1.4." Rounding to the nearest whole number would make the "per day" UOS equal "1." The value of "1" would pass the MUE edit and all 14 UOS billed on the claim line would be paid.

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

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

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

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

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

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

- the maximum UOS allowed by the combination of MUE values for these two CPT codes is nine 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.

Revision Date (Medicaid): 01/01/2020

38

Alternatively, a state Medicaid agency can request Deactivation of the Medicaid MUE for code 90472, if state policy allows more than eight immunization injections for the same beneficiary on the same day and if the state submits sufficient official state documentation of the conflict with state law, regulation, administrative rule, or payment policy.

7.6.2.3 Medically Unlikely Edits for Bilateral Procedures and Items

For surgical procedures for which the code describes a unilateral procedure that can also be performed bilaterally, the MUE value is generally set as one. 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 one 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 two claim lines (e.g., one with the RT modifier and one UOS and the other with the LT modifier and one UOS), but this is not the recommended approach.

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

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

7.6.2.4 Medically Unlikely Edits with a Value of zero

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

Revision Date (Medicaid): 01/01/2020

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

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

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

States may make "individual case exceptions" to an MUE denial, if they determine that the service is correctly coded and is medically necessary, which would include whether it was performed in an appropriate setting.[33]

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

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

- when the unit of measure that a state directs providers to use for a HCPCS/CPT code in filing a Medicaid claim is different from the unit of measure that was used to set

---

[33] See section 7.4.1.

the MUE value for that code, e.g., when the unit of measure for establishing an MUE for a particular code is "per visit or encounter" and the state directs providers to bill that code on Medicaid claims with a unit of measure of "15-minute" increments;

- when the state requires prior (service) authorization for Medicaid payment of a code and the prior authorization process includes a determination of the allowable number of UOS to be provided to, and paid for, the Medicaid beneficiary; and

- when the state has a published policy that allows more UOS per day than the MUE value.

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

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

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

- Is prior authorization required for the code in all situations or only in certain situations (e.g., specific provider types, specific programs, or only if the UOS exceed a specific value)?

- Is the individual code that is being prior authorized identified and noted in the beneficiary's record or is the prior authorization only for a general plan of care?

- Is the specific number of UOS prior authorized noted in the beneficiary's record and enforced at the time of claim adjudication?

- Is the prior authorization for services / items rendered / dispensed on a single DOS or over a span of time?

Revision Date (Medicaid): 01/01/2020

41

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

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

7.6.3 State-Specific Units-of-Service Edits

If a previously existing state or contractor Medicaid edit is identical to a Medicaid NCCI edit (i.e., same beneficiary, same provider, and same date of service), the edit is now considered to be a Medicaid NCCI edit, not a state or contractor edit. State or contractor edits that exactly duplicate Medicaid NCCI edits can either be deactivated or be applied after the Medicaid NCCI edits are applied to a Medicaid claim.

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

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

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

Revision Date (Medicaid): 01/01/2020

42

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

7.7 CLEIDS and Edit Rationales

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

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

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

7.8 Add-On Code Edits

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

Revision Date (Medicaid): 01/01/2020

43

Add-on code edits are now part of the Medicare NCCI program, but are optional for state Medicaid agencies to use. If a state Medicaid agency chooses to implement add-on code edits, these edits and any resulting denials should be characterized as state-specific edits / denials; they should not be characterized as NCCI edits / denials.

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 Procedure-to-Procedure Edits

PTP claim-adjudication rules identify specific PTP-associated modifiers which are needed to bypass PTP edits which have a CCMI of "1." PTP-associated modifiers may be appended, 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 one of these modifiers to a HCPCS/CPT code that is one of the codes in a PTP edit with a CCMI of "1," the PTP edit must be bypassed. PTP-associated modifiers are 24, 25, 27, 57, 58, 59, 78, 79, 91, E1 – E4, F1 – F9, FA, LC, LD, LM, LT, RC, RI, RT, T1 – T9, TA, XE, XP, XS, and XU. (Modifiers XE, XP, XS, and XU are valid for claims with dates of service on or after January 1, 2015.)

A separate and distinct E&M service is billed with modifier 24, 25, or 57[34]. Modifiers 24, 25, and 57 should only be appended to an E&M code (99201 – 99499, 92002-92014), regardless of whether the E&M code is the Column 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 date of service, a state's MES must allow modifier 25 to bypass the PTP

---

[34] Modifiers 24 and 57 are used with E&M codes only when the related code is a surgery service.

Revision Date (Medicaid): 01/01/2020

edits for these codes, so that both the immunization administration and preventive-medicine E&M codes will be paid.

MLN Matters® article SE1418 contains information on the proper use of modifier 59. Additional information about modifier 59 is found in Section E of Chapter 1 of the Medicaid NCCI Policy Manual for Medicaid Services.

The anatomical PTP-associated modifiers are E1 – E4, F1 – F9, FA, LC, LD, LM, LT, RC, RI, RT, T1 – T9, and TA. A state's 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 one of the codes also has modifier 59, a PTP edit with a CCMI of "1" should be bypassed.

8.2 Modifiers Associated with Medically Unlikely Edits

Refer also to Section 7.6.2.3 Medically Unlikely Edits for Bilateral Procedures and Items

The modifier that has a direct impact on the adjudication of Medicaid claims with MUEs is modifier 55.[35] 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

---

[35] This differs from the claim-adjudication rules for NCCI PTP edits. These rules direct that the PTP edit be bypassed, if the Correct Coding Modifier Indicator (CCMI) for the edit is "1" and if one of the 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.

Revision Date (Medicaid): 01/01/2020

does implement its own edits related to the appropriate use of modifiers, the edits must be characterized as state edits, not as NCCI edits.

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

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

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

Appendix A: List of 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

Revision Date (Medicaid): 01/01/2020

46

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 and Management

FFP: Federal Financial Participation

FFS: Fee-For-Service

FQHC: Federally Qualified Health Center

HCPCS: Healthcare Common Procedure Coding System

MCO: Managed Care Organization

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

Revision Date (Medicaid): 01/01/2020

OPH: Outpatient Hospital

PCCM: Primary Care Case Management

PRA: Practitioner

PTP: Procedure-to-Procedure

RHC: Rural Health Clinic

SSA: Social Security Act

TGM: Technical Guidance Manual

UOS: Units of Service

Revision Date (Medicaid): 01/01/2020

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

NCCI PTP Edit Characteristics

    (F) NCCI PTP edits apply to services by same provider to same beneficiary on same date of service. 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

Revision Date (Medicaid): 01/01/2020

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 NCCI.

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 evaluation and management (E&M) code (99201 – 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.

Medicaid NCCI does not require that modifier 59 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 Modifier 59 article and the NCCI Policy Manual for Medicaid Services for specific information regarding modifier usage, which can be found on the Medicaid.gov website at:

https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

Revision Date (Medicaid): 01/01/2020

51

NCCI PTP Claim Adjudication Rules

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

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

    (a) The Practitioner 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 NCCI PTP edit 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 Outpatient Hospital 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.

    (d) Either the Durable Medical Equipment, Practitioner, or Outpatient Hospital NCCI PTP edit file should be applied to Medicaid claims for durable medical equipment, prosthetics, orthotics, and supplies. Identical edits for these items are present in all three 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 date of service for the same provider and same beneficiary. This is the subset of HCPCS/CPT codes for each code that needs to be tested against the NCCI procedure-to-procedure edit files.

    (a) For **each** code in the subset, use it as a Column One code and pair it with every other code in the subset as a Column Two code. Each code is paired with **every other** code as both Column One and Column Two codes. (Note that this method

Revision Date (Medicaid): 01/01/2020

52

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.

(b) After code pairs that match NCCI PTP edits in the edit file are identified, test the date of service against the effective date and deletion date (if relevant) for each edit. Apply the NCCI PTP edit to the claim only if the date of service is "on or after" the effective date and "on or before" the deletion date of the edit. Most edits do not have deletion dates. 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.)

(c) 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.

(d) 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:

  (i) 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.

  (ii) 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.

Revision Date (Medicaid): 01/01/2020

53

          (iii) 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.

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

(e) 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 follow:

          (i) Provider Payment Notice Advice alternatives:

             i. "Payment denied based on NCCI edit."

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

           iii. Do NOT state: "Payment denied because service is component of another service (or integral to another service) on same date of service." 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.

(f) 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.

Revision Date (Medicaid): 01/01/2020

54

Because reported HCPCS/CPT codes for the same date of service on the current claim are tested with all other codes with the same date of service from claims in history, it is possible that an NCCI 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, Sections 7.3 – 7.3.3.

Revision Date (Medicaid): 01/01/2020

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

MUE Edit 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.

(2) An MUE is a claim line edit, **not** an entire claim edit. That is, the MUE is applied separately to the UOS reported on each line of a claim. It is NOT applied to the sum total UOS for a code on the entire claim.

(3) An MUE is **not a date of service edit. It is not applied to the sum of all UOS for a code with the same date of service.**

(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

Revision Date (Medicaid): 01/01/2020

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.

Revision Date (Medicaid): 01/01/2020

MUE Claim Adjudication Rules

(1) Apply edits to services by same provider for same beneficiary on same date of service.
(2) Determine whether the type of claim and the site of service are subject to MUE edits.
   (a) The Practitioner 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 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 Outpatient Hospital MUE 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 one of the Durable Medical Equipment, Practitioner, or Outpatient Hospital MUE files should be applied to Medicaid claims for DMEPOS Identical edits for these items are present in all three 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

Revision Date (Medicaid): 01/01/2020

58

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 02/01/2012 and the "To" date listed on the claim is 02/10/2012. The submitted UOS on the claim are 14. The "From" and "To" dates equal 10day 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 medically unlikely edit.

(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 date of service from prior claims in history with same date of service 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

Revision Date (Medicaid): 01/01/2020

59

misusing modifiers to report the same code on more than two lines of a claim. Caution is necessary when developing this type of duplicate logic.

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

   (13) Caution: 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 durable medical equipment that can be performed or used bilaterally, the MUE value is generally set as "2" to permit the billing of bilateral procedures / items on a single claim line with two UOS. As with surgical procedures, states have the option to instruct providers to report bilateral procedures / items on separate claim lines.

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

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, Sections 7.3 – 7.3.3.

Appendix D: File Types and File Names

FILE TYPES

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

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

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

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

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

- The Medicaid Integrity Institute (MII) located on 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 Edit Files page of Medicaid NCCI homepage on the Center for Medicaid and CHIP Services (CMCS) CMS website: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

There are two 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 changes for the quarterly release

MII Files – File Formats

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

Revision Date (Medicaid): 01/01/2020

61

- 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 three formats are:

- Fixed-Width ASCII text
- Tab-delimited ASCII text
- Excel 2007/2010

The PTP and MUE Change Report files posted to the MII are prepared in two formats:

- Tab-delimited ASCII text
- Excel 2007/2010

Publicly Available Files – File Formats

The quarterly NCCI PTP and MUE complete edit files posted to the CMS public website at: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html are posted as data tables.

The quarterly NCCI PTP and MUE complete edit files and Change Report files posted to the CMS public website at: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html are prepared in two file formats.

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

The two formats are:

- Tab-delimited ASCII text
- Excel 2007/2010

Revision Date (Medicaid): 01/01/2020

Important Notes:

- State Medicaid agencies shall only use the quarterly Medicaid NCCI complete edit files that are posted on the MII 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.

Revision Date (Medicaid): 01/01/2020

FILE NAMES

Complete Edit Files

For the complete edit files posted to the MII, 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 2007/2010
   File extension - .txt – Fixed-Width ASCII Text and Tab-
     Delimited ASCII Text; .xlsx – Excel

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

For example, the initial final versions of the January 2013 MII files were named:

  MCD-PTP-PRA-v2013q1-F1-T.txt
  MCD-PTP-PRA-v2013q1-F1-D.txt
  MCD-PTP-PRA-v2013q1-F1-E-Part 1.xlsx
  MCD-PTP-PRA-v2013q1-F1-E-Part 2.xlsx
  MCD-PTP-OPH-v2013q1-F1-T.txt
  MCD-PTP-OPH-v2013q1-F1-D.txt
  MCD-PTP-OPH-v2013q1-F1-E-Part 1.xlsx
  MCD-PTP-OPH-v2013q1-F1-E-Part 2.xlsx
  MCD-PTP-DME-v2013q1-F1-T.txt
  MCD-PTP-DME-v2013q1-F1-D.txt
  MCD-PTP-DME-v2013q1-F1-E.xlsx

  MCD-MUE-PRA-v2013q1-F1-T.txt
  MCD-MUE-PRA-v2013q1-F1-D.txt
  MCD-MUE-PRA-v2013q1-F1-E.xlsx
  MCD-MUE-OPH-v2013q1-F1-T.txt
  MCD-MUE-OPH-v2013q1-F1-D.txt
  MCD-MUE-OPH-v2013q1-F1-E.xlsx
  MCD-MUE-DME-v2013q1-F1-T.txt

<div align="center">

Revision Date (Medicaid): 01/01/2020

64

</div>

```
MCD-MUE-DME-v2013q1-F1-D.txt
MCD-MUE-DME-v2013q1-F1-E.xlsx
```

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

Change Report Files:

For Change Report files posted to the MII 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 2013 Change Report files were named:

```
MCD_PTP_PRA_Adds_Eff_01-01-2013.txt
MCD_PTP_PRA_Dels_Eff_01-01-2013.txt
MCD_PTP_PRA_CCMI_Changes_Eff_01-01-2013.txt
MCD_PTP_PRA_Changes_Eff_01-01-2013.xlsx

MCD_PTP_OPH_Adds_Eff_01-01-2013.txt
MCD_PTP_OPH_Dels_Eff_01-01-2013.txt
MCD_PTP_OPH_CCMI_Changes_Eff_01-01-2013.txt
MCD_PTP_OPH_Changes_Eff_01-01-2013.xlsx

MCD_PTP_DME_Adds_Eff_01-01-2013.txt
MCD_PTP_DME_Dels_Eff_01-01-2013.txt
MCD_PTP_DME_CCMI_Changes_Eff_01-01-2013.txt
MCD_PTP_DME_Changes_Eff_01-01-2013.xlsx

MCD_MUE_PRA_Adds_Eff_01-01-2013.txt
MCD_MUE_PRA_Dels_Eff_01-01-2013.txt
MCD_MUE_PRA_Rev_Eff_01-01-2013.txt
MCD_MUE_PRA_Changes_Eff_01-01-2013.xlsx

MCD_MUE_OPH_Adds_Eff_01-01-2013.txt
```

Revision Date (Medicaid): 01/01/2020

65

MCD_MUE_OPH_Dels_Eff_01-01-2013.txt
MCD_MUE_OPH_Rev_Eff_01-01-2013.txt
MCD_MUE_OPH_Changes_Eff_01-01-2013.xlsx

MCD_MUE_DME_Adds_Eff_01-01-2013.txt
MCD_MUE_DME_Dels_Eff_01-01-2013.txt
MCD_MUE_DME_Rev_Eff_01-01-2013.txt
MCD_MUE_DME_Changes_Eff_01-01-2013.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).

Revision Date (Medicaid): 01/01/2020

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

MII FORMATS – NCCI PTP COMPLETE EDIT FILES

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

1. Fixed-Width ASCII Text
2. Tab-Delimited ASCII Text
3. Excel 2007/2010

Fixed-Width ASCII Text Format

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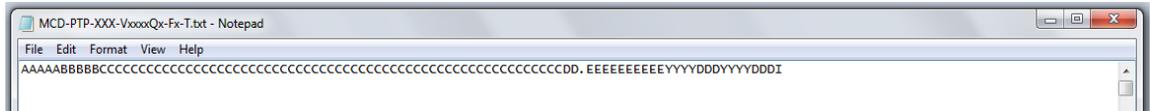
    (2) There will be three separate final NCCI PTP MII edit files. Their file names will be:
      a. Practitioner/ASC NCCI PTP edit file: **MCD-PTP-PRA-vXXXXqX-FX-T.txt**
      b. Outpatient Hospital NCCI PTP edit file: **MCD-PTP-OPH-vXXXXqX-FX-T.txt**
      c. Durable Medical Equipment (DME) NCCI PTP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

Revision Date (Medicaid): 01/01/2020

Field Name	Notes	Type	Beg. Char	# of Char
Standard Policy Statement (no label)	CCCCCCCCCCCCCCCCCCCCCCCCC CCCCCCCCCCCCCCCCCCCCCCCCCC CCCCCCCC **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

Revision Date (Medicaid): 01/01/2020

68

Field Name	Notes	Type	Beg. Char	# of Char
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 four 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

Revision Date (Medicaid): 01/01/2020

69

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 MII edit file:
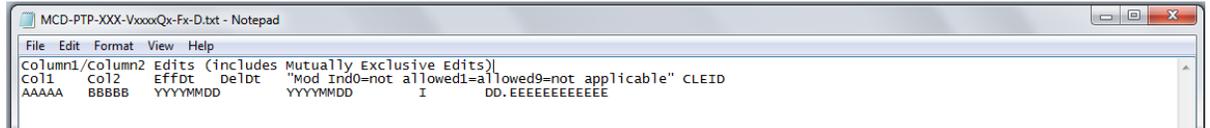
Tab-Delimited ASCII Text Format

(1) In the NCCI procedure-to-procedure (PTP) MII edit files in tab-delimited ASCII text format, each edit will have the following format:


```
MCD-PTP-XXX-VxxxxQx-Fx-D.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
AAAAA   BBBBB   YYYYMMDD        YYYYMMDD        I       DD.EEEEEEEEEEEE
```

(2) There will be three separate final NCCI PTP MII edit files. Their file names will be:
   a. Practitioner/ASC NCCI PTP edit file: **MCD-PTP-PRA-vXXXXqX-FX-D.txt**
   b. Outpatient Hospital 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	Numeric	tab	8

Revision Date (Medicaid): 01/01/2020

71

Field Name	Notes	Type	Delimiter	# of Char
	ACTIVE from the date in the Effective Date field.			
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

Revision Date (Medicaid): 01/01/2020

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 four 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:
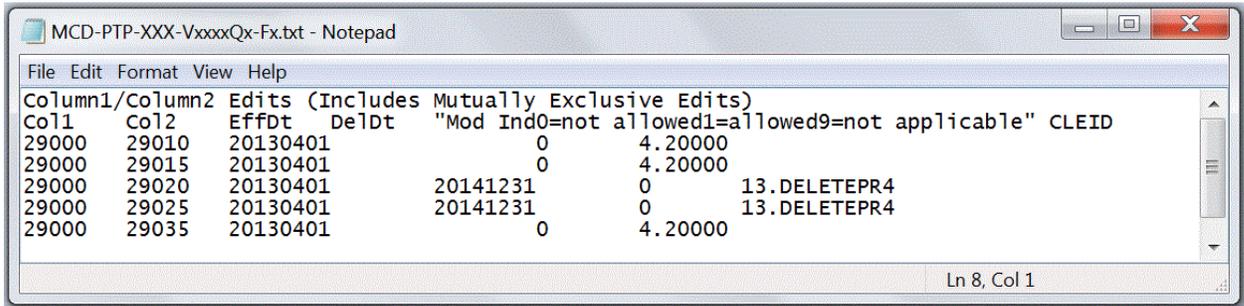
Please note – In tab-delimited text files, the records may not align with the column headings or from row to row. This is because of the logic that tells the computer where to place certain values when the data is imported into

Revision Date (Medicaid): 01/01/2020

other applications. For example, on rows for edits that do not have a deletion date, the Correct Coding Modifier Indicator will appear aligned. But, on rows for edits that do have a deletion date, the Correct Coding Modifier Indicator will appear to shift to the right. Even though they appear skewed to the reader's eye, from a programming standpoint, the Correct Coding Modifier Indicator in both lines will be in the same position.

Revision Date (Medicaid): 01/01/2020

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

```
MCD-PTP-XXX-VxxxxQx-Fx.txt - Notepad                            _  □  X

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
```

Revision Date (Medicaid): 01/01/2020

75

Excel 2007/2010 Format

(1) In the NCCI procedure-to-procedure (PTP) MII edit files in Excel 2007/2010 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 two separate final NCCI PTP MII edit files. Their file names will be:
   a. Practitioner/ASC NCCI PTP edit file: **MCD-PTP-PRA-vXXXXqX-FX-E.xlsx**
   b. Outpatient Hospital 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
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

Revision Date (Medicaid): 01/01/2020

76

Column Name	Notes	Type
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.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 four 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

The following is an example of a section of an Excel 2007/2010 NCCI PTP MII edit file:

Revision Date (Medicaid): 01/01/2020

77

	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		0	14.0000M
6	0001M	80053	20170401		0	14.0000M

PUBLICLY AVAILABLE FORMAT – NCCI PTP COMPLETE EDIT FILES

The NCCI Procedure-to-Procedure (PTP) complete edit files are posted to the CMS Medicaid.gov website as data tables. An example of the data table format for Medicaid NCCI PTP complete edit files is:

The columns and possible values in the table are:
- Quarter Begin Date
- Category
    - Practitioner Services
    - Outpatient Hospital Services
    - DME Services
- Column 1
    - CPT or HCPCS code
- Column 2
    - CPT or HCPCS Code

Revision Date (Medicaid): 01/01/2020

- Effective Date
- Deletion Date
- Modifier Indicator
  - 0 – Edit will not be bypassed by use of an NCCI PTP-associated modifier
  - 1 – Edit will be bypassed by use of an NCCI PTP-associated modifier
  - 9 – Edit terminated retroactively; edit does not apply
- PTP Edit Rationale
  - See Appendix G for list of rationales

There are several tabs at the top of each table that allow users to manipulate the data:
- Manage
  - Allows user to change the order of the columns
- More Views
  - Allows user to select other NCCI files

- Filter
  - Conditional Formatting – User can change the background color of rows based on custom criteria. Each row will be assigned the color of the first matching condition.
  - Sort & Roll-Up - User can group rows together and summarize data with a roll-up; and sort one or more columns.
  - Filter – User can filter dataset based on contents.
- Visualize
  - Calendar, Map, Chart – Not applicable to PTP edits
- Export
  - The table can be downloaded in various formats. Note that when downloading in CSV or CSV for Excel those formats allow a maximum of 1,048,576 rows. There are more rows than that in the Practitioner and Outpatient Hospital PTP edit files. Therefore, if the user wants to obtain those complete files in CSV or CSV for Excel format, the user will need to filter the data and download in two separate files the complete file.

**Revision Date (Medicaid): 01/01/2020**

79

PUBLICLY AVAILABLE AND MII FORMATS –NCCI PTP CHANGE REPORT FILES

The NCCI Procedure-to-Procedure (PTP) Change Report files are posted to the CMS Medicaid.gov website and MII in two formats. The specifications for each format and sample screen prints have been included on the following pages. The two formats are:
1. Tab-Delimited ASCII Text
2. Excel 2007/2010

Tab-Delimited ASCII Text Format

   (1) In the NCCI procedure-to-procedure (PTP) Change Report files in tab-delimited ASCII text format, each file will have the following format:
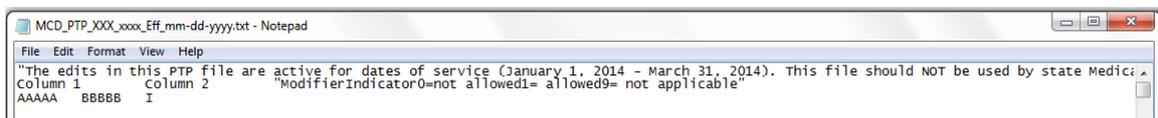
   (2) There will be nine separate NCCI PTP Change Report files in this format. The tab-delimited ASCII text Publicly Available files do not indicate a version number, but rather include the date the file becomes effective.
   (3) In this format, there will be separate files for each provider type (PRA/OPH/DME) 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.

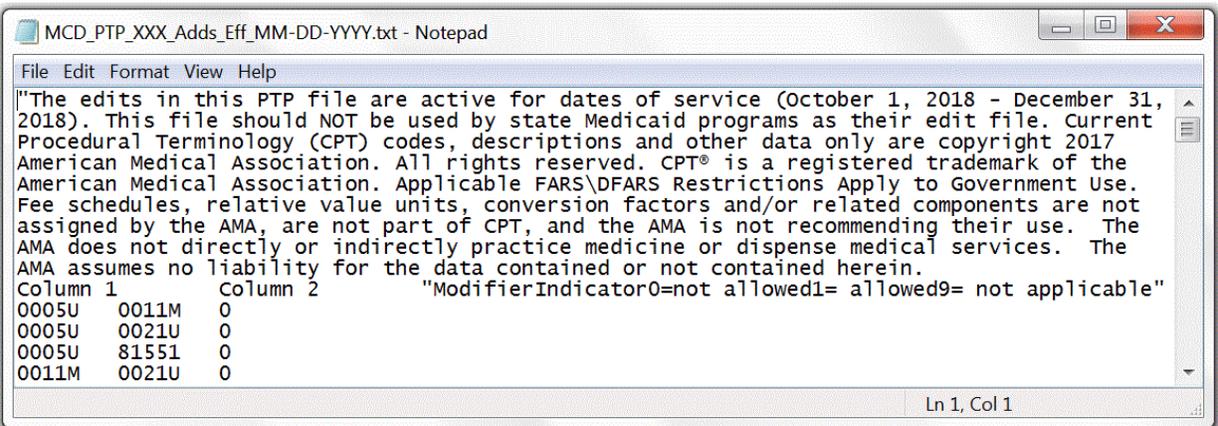| Field Name	Notes	Type	Delimiter	# of Char
Column 1 code (labeled Col1)	AAAAA	Alpha-Numeric Text	Tab	5
Column 2 code (labeled Col2)	BBBBB	Alpha-Numeric Text	tab	5

Revision Date (Medicaid): 01/01/2020

Field Name	Notes	Type	Delimiter	# of Char
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

Revision Date (Medicaid): 01/01/2020

81

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

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 will appear aligned. But, on rows for edits that
do have a deletion date, the Correct Coding Modifier
Indicator will appear to shift to the right. Even though
they appear skewed to the reader's eye, from a programming
standpoint, the Correct Coding Modifier Indicator 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.**

Revision Date (Medicaid): 01/01/2020

Excel 2007/2010 Format

    (1) In the NCCI procedure-to-procedure (PTP) Change Report file in Excel 2007/2010 format, each file will have the following format:

	A	B	C
1	The edits in this PTP file are active for dates of service (January 1, 2014 - March 31, 2014). This file should NOT be used by state Medicaid programs as their edit file. Current Procedural Terminology © 2013 American Medical Association. All Rights Reserved. Current Procedural Terminology (CPT) is copyright 2013 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.		
2	Column 1	Column 2	Modifier Indicator 0=not allowed 1= allowed 9= not applicable
3	AAAAA	BBBBB	I

    (2) There will be three separate NCCI PTP Change Report files. The Excel 2007/2010 files do not indicate a version number, but rather include the date the file becomes effective. Each Excel file will contain three worksheets/tabs to identify additions, deletions, and CCMI changes. The file names will be:
    a. Practitioner/ASC NCCI PTP edit file:
       MCD_PTP_PRA_Changes_Eff_mm-dd-yyyy.xlsx
    b. Outpatient Hospital NCCI PTP edit file:
       MCD_PTP_OPH_Changes_Eff_mm-dd-yyyy.xlsx
    c.   Durable Medical Equipment (DME) NCCI PTP edit file:
       M**CD_PTP_DME_Changes_Eff_mm-dd-yyyy.xlsx**

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

Revision Date (Medicaid): 01/01/2020

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:

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

Current Procedural Terminology © 20xx American Medical Association. All Rights Reserved.

Current Procedural Terminology (CPT) is copyright 20xx American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

CPT® is a trademark of the American Medical Association.

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

Revision Date (Medicaid): 01/01/2020

The following is an example of a section of an Excel 2007/2010
NCCI PTP Change Report file:

	A	B	C
	The edits in this PTP file are active for dates of service (October 1, 2018 - December 31, 2018). 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 2017 American Medical Association. All rights reserved.		
	CPT® is a registered trademark of the American Medical Association.		
	Applicable FARS\DFARS Restrictions Apply to Government Use.		
L	*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.*		
			Modifier Indicator 0=not allowed 1= allowed
2	**Column 1**	**Column 2**	9= not applicable
3	0005U	0011M	0
4	0005U	0021U	0
5	0005U	81551	0
6	0011M	0021U	0

MCD_PTP_PRA_Adds_Eff10-01-2018 / MCD_PTP_PRA_Dels_Eff10-01-2018 / MCDPTP_PRA_CCMIChgs_Eff10-

Revision Date (Medicaid): 01/01/2020

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

MII FORMATS – MUE COMPLETE EDIT FILES

The NCCI Medically Unlikely Edit (MUE) complete edit files are posted to the MII in three formats. The specifications for each format and sample screen prints have been included on the following pages. The three formats are:
1. Fixed-Width ASCII Text
2. Tab-Delimited ASCII Text
3. Excel 2007/2010

Fixed-Width ASCII Text Format

(1) In the MUE MII edit files in fixed-width ASCII format, each edit will have the following format:
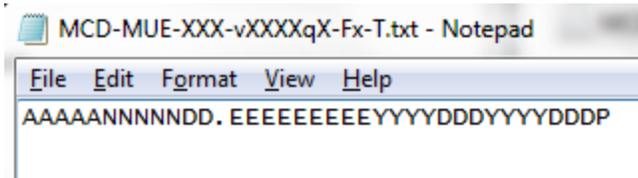
(2) There will be three separate final MUE MII edit files:
(a) Practitioner MUE edit file named **MCD-MUE-PRA-vXXXXqX-FX-T.txt** There is one edit file that applies to:
   (i) Practitioner services AND
   (ii) Ambulatory surgical center (ASC) services.
(b) Outpatient Hospital MUE edit file named **MCD-MUE-OPH-vXXXXqX-FX-T.txt** There is one edit file that applies to:
   (i) Outpatient hospital 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

Revision Date (Medicaid): 01/01/2020

(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 outpatient hospital services contains MUEs for DME billed by a hospital.

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

Revision Date (Medicaid): 01/01/2020

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

Revision Date (Medicaid): 01/01/2020

Field Name	Notes	Type	Beg. Char.	# of Char.
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 four 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

Revision Date (Medicaid): 01/01/2020

89

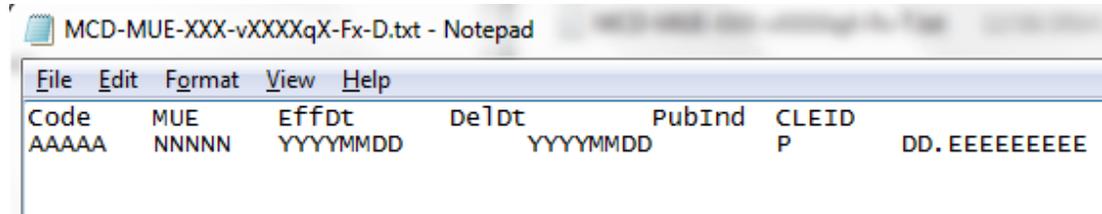| Field Name	Notes	Type	Beg. Char.	# of Char.
Deletion Date (no label)	Julian date format: yyyyddd Edits with <blank> Deletion Date values are ACTIVE from the date in the Effective Date field.	Numeric	30	7
Publication Indicator	P Valid values = 0 or 1 0 = not published – confidential Do not share – for 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 MII edit file:
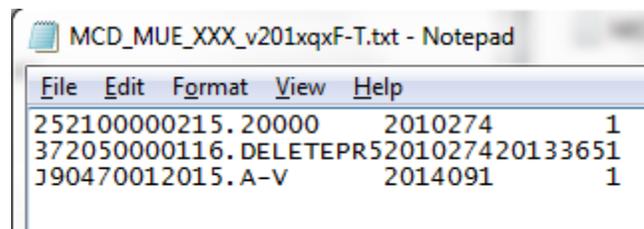
Revision Date (Medicaid): 01/01/2020

90

Tab-Delimited ASCII Text Format

(1) In the MUE MII edit files in tab-delimited ASCII text format, each edit will have the following format:

```
MCD-MUE-XXX-vXXXXqX-Fx-D.txt - Notepad
File  Edit  Format  View  Help
Code    MUE     EffDt           DelDt           PubInd  CLEID
AAAAA   NNNNN   YYYYMMDD         YYYYMMDD        P       DD.EEEEEEEEE
```

(2) There will be three separate final MUE MII edit files:
- (a) Practitioner MUE file named **MCD-MUE-PRA-vXXXXqX-FX-D.txt.** There is one edit file that applies to:
    - (i) Practitioner services AND
    - (ii) Ambulatory surgical center (ASC) services.
- (b) Outpatient Hospital MUE edit file named **MCD-MUE-OPH-vXXXXqX-FX-D.txt.** There is one edit file that applies to:
    - (i) Outpatient hospital 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 outpatient hospital services contains MUEs for DME billed by a hospital.

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

Revision Date (Medicaid): 01/01/2020

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

Revision Date (Medicaid): 01/01/2020

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 four 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.

Revision Date (Medicaid): 01/01/2020

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.

Revision Date (Medicaid): 01/01/2020

The following is an example of a section of a tab-delimited
ASCII text MUE MII edit file:
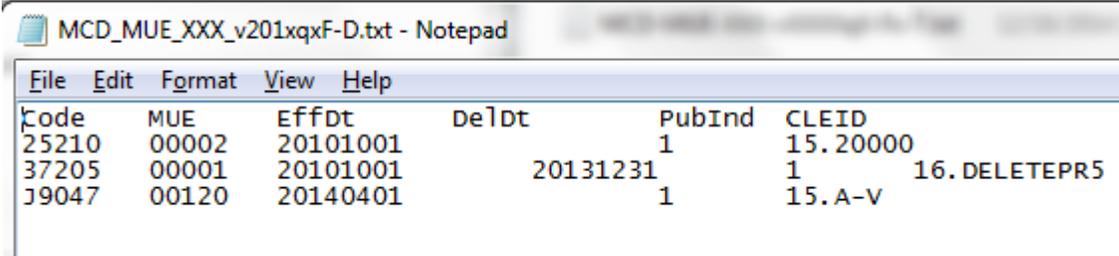
```
MCD_MUE_XXX_v201xqxF-D.txt - Notepad

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
```

Excel 2007/2010 Format

(1) In the MUE MII edit files in Excel 2007/2010 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 three separate final MUE MII edit files:
  (a) Practitioner MUE edit file named **MCD-MUE-PRA-vXXXXqX-FX-E.xlsx.** There is one edit file that applies to:
      (i) Practitioner services AND
      (ii) Ambulatory surgical center (ASC) services.
  (b) Outpatient Hospital MUE edit file named **MCD-MUE-OPH-vXXXXqX-FX-E.xlsx.** There is one edit file that applies to:
      (i) Outpatient hospital 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 outpatient hospital services contains MUEs for DME billed by a hospital.

Revision Date (Medicaid): 01/01/2020

96

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

Revision Date (Medicaid): 01/01/2020

Column Name	Notes	Type
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 four 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 MII 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	00120	20140401		1	15.A-V

Revision Date (Medicaid): 01/01/2020

PUBLICLY AVAILABLE FORMAT – MUE COMPLETE EDIT FILES

The NCCI Medically Unlikely Edit (MUE) files are posted to the CMS Medicaid.gov website as data tables. An example of the data table format for Medicaid NCCI MUE files is:

The columns and possible values in the table are:
- Quarter Begin Date
- Category
    o Practitioner Services
    o Outpatient Hospital Services
    o DME Services
- HCPCS/CPT Code
- MUE Value
- MUE Rationale
    o See Appendix H for list of rationales

There are several tabs at the top of each table that allow users to manipulate the data:
- Manage
    o Allows user to change the order of the columns
- More Views
    o Allows user to select other NCCI files
- Filter
    o Conditional Formatting – User can change the background color of rows based on custom criteria. Each row will be assigned the color of the first matching condition.

Revision Date (Medicaid): 01/01/2020

- o Sort & Roll-Up - User can group rows together and summarize data with a roll-up; and sort one or more columns.
- o Filter – User can filter dataset based on contents.
- Visualize
  - o Calendar, Map, Chart – Not applicable to PTP edits
- Export
  - o The table can be downloaded in various formats. Note that when downloading in CSV or CSV for Excel those formats allow a maximum of 1,048,576 rows. There are more rows than that in the Practitioner and Outpatient Hospital PTP edit files. Therefore, the user will need to filter the data before downloading the complete file.

**Revision Date (Medicaid): 01/01/2020**

PUBLICLY AVAILABLE AND MII FORMATS – MUE CHANGE REPORT FILES

The NCCI Medically Unlikely Edit (MUE) Change Report files are posted to the CMS Medicaid.gov website and the MII in two formats. The specifications for each format and sample screen prints have been included on the following pages. The two formats are:

    (1)   Tab-Delimited ASCII Text
    (2)   Excel 2007/2010

Tab-Delimited ASCII Text Format

    (1) In the Medically Unlikely Edit (MUE) Change Report files in tab-delimited ASCII text format, each file will have the following format:
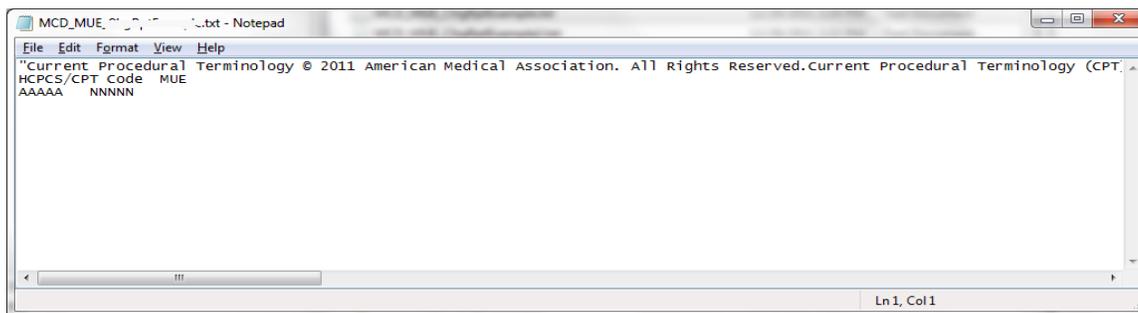
    (2) There will be nine separate MUE Change Report files. The tab-delimited ASCII text files do not indicate a version number, but rather include the date the file becomes effective.
    (3) Refer to Appendix D for the complete list of file names.

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

Revision Date (Medicaid): 01/01/2020

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

```
MCD_MUE_...........2.txt - Notepad
File  Edit  Format  View  Help
"Current Procedural Terminology © 2011 American Medical Association. All Rights Reserved.Current Procedural Terminology (CPT
HCPCS/CPT Code   MUE
A4234    3
A4236    2
A4356    1
A4396    3
A4399    2
A4463    3
A4604    1
A4612    2
A4613    1
A4636    2
A5102    1
A7005    1
A7010    2
A7014    1

                                                                          Ln 1, Col 1
```

**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.**

Revision Date (Medicaid): 01/01/2020

103

Excel 2007/2010 Format

    (1) In the Medically Unlikely Edit (MUE) Change Report file in Excel 2007/2010 format, each file will have the following format:
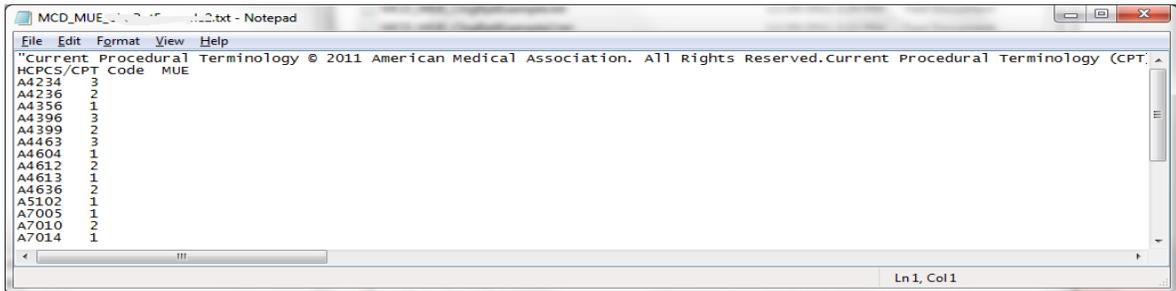
Current Procedural Terminology © 2011 American Medical Association. All Rights Reserved. Current Procedural Terminology (CPT) is copyright 2011 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.	
HCPCS/CPT Code	**MUE**
AAAAA	NNNNN

    (2) There will be three separate MUE Change Report files. The Excel 2007/2010 files do not indicate a version number, but rather include the date the file becomes effective. Their file names will be:
    (a) Practitioner/ASC MUE file:
      MCD_MUE_PRA_Changes_Eff_mm-dd-yyyy.xlsx
    (b) Outpatient Hospital 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

Revision Date (Medicaid): 01/01/2020

Column Name	Notes	Type
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 2007/2010
MUE Change Report file:

A	B
The edits changes in this MUE change report are effective beginning on October 1, 2018. 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 2017 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	**DME Supplier Services MUE Values**
J8670	180

Notes:

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

Current Procedural Terminology © 20xx American
Medical Association. All Rights Reserved.

Current Procedural Terminology (CPT) is copyright
20xx American Medical Association. All Rights
Reserved. No fee schedules, basic units, relative
values, or related listings are included in CPT.
The AMA assumes no liability for the data contained
herein. Applicable FARS/DFARS restrictions apply to
government use.

CPT® is a trademark of the American Medical
Association.

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

Revision Date (Medicaid): 01/01/2020

Appendix G: Rationale/ Standard Policy Statements – Procedure-to-Procedure Edits

Medicaid Rationale/ Standard Policy Statements for PTP Edits	
Policy ID	**Edit Rationale/ Standard Policy Statement**
1	Standard preparation / monitoring services for anesthesia
2	HCPCS/CPT procedure code definition
3	CPT Manual or NCCI program instructions
4	Mutually exclusive procedures
5	Sequential procedures
6	CPT "separate procedure" definition
7	More extensive procedure
8	Reserved for future use
9	Gender-specific procedures
10	Standards of medical / surgical practice
11	Anesthesia service included in surgical procedure
12	Laboratory panel
13	Deleted NCCI PTP edit
14	Misuse of Column Two code with Column One code

Revision Date (Medicaid): 01/01/2020

Appendix H: Rationale – 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

Revision Date (Medicaid): 01/01/2020

Revision Date (Medicaid): 01/01/2020