CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13701	**Date: June 16, 2026**
	Change Request 14428

SUBJECT: Update to Several Sections of the Internet-Only Manual (IOM) Publication (Pub.) 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Sections 20.9, 20.9.3.1, and 20.9.3.2.

EFFECTIVE DATE: July 16, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 16, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/20.9/National Correct Coding Initiative (NCCI)
R	23/20.9.3.1/Procedure-to-Procedure (PTP) Edits
R	23/20.9.3.2/Medically Unlikely Edits (MUEs)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 14428	Date: June 16, 2026	Change Request: 14428

SUBJECT: Update to Several Sections of the Internet-Only Manual (IOM) Publication (Pub.) 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements

EFFECTIVE DATE: July 16, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 16, 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Sections 20.9, 20.9.3.1, and 20.9.3.2.

II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update the IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Sections 20.9, 20.9.3.1, and 20.9.3.2.

B. Policy: N/A

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14428.1	Medicare Administrative Contractors (MACs) shall be aware of the revisions to IOM Pub. 100-04, Chapter 23, Sections 20.9, 20.9.3.1, and 20.9.3.2.		X		X					
14428.2	When a provider or supplier submits a claim for any of the codes specified (i.e., 77427, 92012-92014, and 99201-99499) with the 59 modifier *or XE, XP, XS, XU*, the A/B MAC shall process the claim as if the modifier were not present.		X							

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

20.9 - National Correct Coding Initiative (NCCI)

(Rev.14428, Issued:06-16-26; Effective:07-16-26; Implementation:07-16-26)

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI program to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. *CMS* developed its coding policies based on coding conventions defined in the American Medical Association's *CPT Professional* codebook, CMS national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. An overview of the NCCI program for Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), Add-on Code (AOC) edits and additional information sources are found on the Medicare NCCI Edits webpage.

The Medicare NCCI Policy Manual (also known as the Coding Policy Manual) shall be used by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits.

The purpose of the NCCI PTP edits is to prevent improper payment when incorrect Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code combinations are reported. The Medicare NCCI Edits webpage contains separate tables of edits for physicians/practitioners and outpatient hospital services. Additional information regarding types of tables is available in the How to Use The Medicare National Correct Coding Initiative (NCCI) Tools MLN booklet.
The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service (UOS). *CMS* developed MUEs to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum UOS that a provider or supplier would report under most circumstances for a single beneficiary on a single date of service. The Medicare NCCI Medically Unlikely Edits (MUEs) webpage contains separate tables of edits for physicians/practitioners, outpatient hospital services, and durable medical equipment.

An AOC is a HCPCS/CPT code that describes a service that**,** with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

CMS posted the Correspondence Language Manual for Medicare Services on the Medicare NCCI Correspondence Language Manual webpage for use by the Medicare Contractors to answer routine correspondence inquiries about the NCCI PTP and MUE edits. The general correspondence language paragraphs explain the rationale for the edits. The section-specific examples add further explanation to the PTP or MUE edits and are sorted by edit rationale and HCPCS/CPT code section (00000, 10000, 20000, etc.). Please refer to the Introduction of the Correspondence Language Manual for additional guidance about its use.

20.9.3.1- Procedure-to-Procedure (PTP) Edits

(Rev.14428, Issued:06-16-26; Effective:07-16-26; Implementation:07-16-26)

All PTP edits have a CCMI.

A denial of services due to a PTP edit is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on a PTP.

PTP edits with a CCMI of "0":

On appeal, if the CCMI is a "0", and the provider or supplier coded the claim correctly, there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider or supplier. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the NCCI edit. In addition, MACs must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Medicare NCCI Correspondence Language Manual.

PTP edits with a CCMI of "1":

On appeal, if the correct coding initiative edit modifier indicator is a "1", the reviewer must determine whether the claim was coded correctly. For example, the reviewer should determine whether the provider or supplier reported an incorrect code, a medically unnecessary service, or simply neglected to use a modifier. The reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of "1" and the reviewer determines that an NCCI *PTP*-associated modifier could have been appended to either code of a correctly coded edit code pair. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the NCCI edit. In addition, MACs must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Medicare NCCI Correspondence Language Manual.

General Instructions on PTPs:

- MACs shall assign CARC 236 with Group Code CO and MSN 16.8 for claims that fail the PTP edits, and deny when this procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI program or workers compensation state regulations/ fee schedule requirements.

20.9.3.2- Medically Unlikely Edits (MUEs)

(Rev.14428, Issued:06-16-26; Effective:07-16-26; Implementation:07-16-26)

All HCPCS/CPT codes with MUE values have an MAI.

MUEs for HCPCS/CPT codes with an MAI of "1": MUEs for HCPCS/CPT codes with an MAI of "1" will be adjudicated as a claim line edit.

MUEs for HCPCS/CPT codes with an MAI of "2": MUEs for HCPCS/CPT codes with an MAI of "2" are absolute date of service edits. These are "per day edits based on policy". HCPCS/CPT codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service in excess of the MUE value would be considered contrary to statute, regulation, or subregulatory guidance. Subregulatory guidance includes clear correct coding policy that is binding on both providers or suppliers and the MACs. As stated in CR 8853, while Qualified Independent Contractors (QICs) are not bound by subregulatory guidance, they should understand the policy nature of the MAI "2" indicator when considering whether to pay UOS in excess of the MUE value if claim denials based on these edits are appealed.

Limitations created by anatomical or coding restrictions are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in the CMS and NCCI Policy manuals. For example, it would be contrary to correct coding policy to report more than 1 unit of service for "ventilation assist and management . . . initial day" because such usage could not accurately describe 2 initial days of management occurring on the same date of service as would be required by the code descriptor.

CMS establishes edits with an MAI of "2" based directly on regulation, statute or subregulatory guidance.

MUEs for HCPCS/CPT codes with an MAI of "3": MUEs for HCPCS/CPT codes with an MAI of "3" are date of service edits. These are "per day edits based on clinical benchmarks". If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS/CPT code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Instructions on MUEs:

- MUEs are set high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that providers or suppliers bring to their attention.

- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to the appropriate MAC not the NCCI contractor. MACs adjudicating an appeal for a claim denial for a HCPCS/CPT code with an MAI of "1" or "3" may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.

- A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an ABN shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3", MACs will review the records to determine if the provider or supplier actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided, but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under Section 1879 of the Social Security Act (the Act) as applying to situations in which a provider or supplier expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI program guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider or supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for UOS denied based on an MUE.

- If a procedure is performed bilaterally and the HCPCS/CPT code descriptor does not state that it is a unilateral or bilateral procedure, report bilateral surgical procedures on a single claim line with modifier 50 and one (1) unit of service. For specific instructions for Ambulatory Surgical Centers, see the Medicare Claims Processing Manual, Chapter 14, Section 40.5.

  When modifier 50 is required by manual or coding instructions, claims submitted with 2 lines or 2 units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in the Medicare Claims Processing Manual, Chapter 34, Section 10.1.

  Clerical errors (which include minor errors and omissions) may be treated as reopenings.

- Providers or suppliers may change and resubmit their own claims where possible but during reopening MACs may, when necessary, correct the claim to modifier 50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR (Integrated Data Repository).

- Providers or suppliers shall use anatomic modifiers (e.g., RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- A/B MACs shall include with the review determination the more detailed explanation of the correct coding initiative edit, which can be found in the standard correspondence language for A/B MACs in the Medicare NCCI Correspondence Language Manual.

- MACs shall assign MSN 15.6. CARC 151 with Group Code CO for claims that fail the MUE edits, when the UOS on the claim exceeds the MUE value, and deny the entire claim line(s) for the relevant HCPCS/CPT code.