CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13216	**Date: May 9, 2025**
	Change Request 14048

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, 20.9.1.1, and 20.9.3.

EFFECTIVE DATE: June 3, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 3, 2025

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	23/20.9.1.1 - Instructions for Codes With Modifiers (A/B MACs (B) Only)
R	23/20.9.3 - Appeals

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: 13216	Date: May 9, 2025	Change Request: 14048

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: June 3, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 3, 2025

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, 20.9.1.1, and 20.9.3.

II. GENERAL INFORMATION

A. Background: 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, 20.9.1.1, and 20.9.3.

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	
14048.1	Medicare Administrative Contractors (MACs) shall be aware of the revisions to IOM Pub. 100-04, Chapter 23, sections 20.9, 20.9.1.1, and 20.9.3.		X		X					
14048.2	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.13216; Issued:05-09-2025; Effective: 06-03-2025; Implementation:06-03-2025)

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. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, 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). The 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.

20.9.1.1 – Instructions for Codes With Modifiers (A/B MACs (B) Only)

(Rev.13216; Issued:05-09-2025; Effective: 06-03-2025; Implementation:06-03-2025)

A. General

MACs subject all line items for the same beneficiary, same NPI, and same date of service to NCCI edits.

All line items for the same beneficiary, same NPI, and same date of service shall be subject to NCCI PTP edits. If the CCMI of a PTP edit is "0", the Column Two code is not eligible for payment even if an NCCI PTP-associated modifier is appropriately appended to one of the codes. If the CCMI of a PTP edit is "1", the edit may be bypassed and the Column Two code of the edit may be eligible for payment if an NCCI PTP-associated modifier is appropriately appended to one of the codes. If the 2 codes of a code pair edit have the same NCCI PTP-associated anatomic modifier, the edit will not be bypassed unless an additional NCCI PTP-associated modifier is appended to 1 of the codes indicating the reason to bypass the edit.

The use of modifiers that are not NCCI PTP-associated modifiers shall not bypass an NCCI PTP edit.

NCCI PTP-associated modifiers are the following:

Anatomic modifiers : E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

B. Modifiers 59 or XE, XP, XS, XU

Modifiers 59 or XE, XP, XS, XU and other NCCI PTP-associated modifiers shall not be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI PTP-associated modifier that is used. Find further information on modifiers 59 or XE, XP, XS, XU in the Coding Policy Manual available on the CMS website.

Use of modifiers 59 or XE, XP, XS, XU does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifiers 59 or XE, XP, XS, XU.

Modifiers 59 or XE, XP, XS, XU shall not be used with the following codes:

- 77427 Radiation treatment management, 5 treatments
- Evaluation & Management (E&M) services

When a provider or supplier submits a claim for any of the codes specified above with modifiers 59 or XE, XP, XS, XU, the A/B MAC must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.1 above, A/B MACs shall convey additional messaging per instructions in Pub. 100-09, Chapter 6 and Pub. 100-04, Chapter 22.

Examples of appropriate use of modifiers 59 and XE, XP, XS, XU can be found in the Fact Sheet Proper Use of Modifiers 59, XE, XP, XS, & XU.

1. Modifier 59 or XE are used appropriately when the procedures are performed in different encounters on the same day.

2. Modifier 59 or XP are used appropriately when the procedures are performed by different practitioners.

3. Modifier 59 or XS are used appropriately for different anatomic sites during the same encounter only when procedures are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

4. Other specific appropriate uses of modifiers 59 or XE, XU.
There are 3 other limited situations in which 2 services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter.

a. Modifier 59 or XE is used appropriately for 2 services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifiers 59 or XE that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If 2 timed services are provided in blocks of time that are separate and distinct (i.e., the same time block is not used to determine the unit of service for both codes), modifier 59 may be used to identify the services.

b. Modifier 59 or XU is used appropriately for a diagnostic procedure, which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or on-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention; and d) it is not specifically prohibited. If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

c. Modifier 59 or XU is used appropriately for a diagnostic procedure, which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

5. Modifiers 59 or XE, XP, XS, XU are used inappropriately if the basis for their use is that the narrative description of the 2 codes is different.

C. Modifier 91

Modifier 91 may be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day when appropriate. If a HCPCS/CPT code has an MUE that is adjudicated as a claim line

edit, (i.e., MUE Adjudication Indicator (MAI) equal to "1") appropriate use of CPT modifiers (i.e., 59 or XE, XP, XS, XU, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. This modifier indicates to the Medicare contractors that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier must not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

For example, if a laboratory performs all tests included in a panel of laboratory tests and repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the HCPCS/CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended.

D. Reserved for future use

E. Coding for Noncovered Services and Services Not Reasonable and Necessary

For information on this topic, see the Claims Processing Manual, Chapter 1 and MLN Booklet: Medicare Advance Written Notices of Noncoverage ICN 006266.

Use of HCPCS Code A9270

HCPCS code A9270 (Non-covered item or service), will not be accepted under any circumstances for services or items billed to A/B MACs. However, in cases where there is no specific procedure code for an item or supply and no appropriate Not Otherwise Classified (NOC) code available, A9270 must continue to be used by suppliers to bill DME MACs for statutorily non-covered items or supplies and items or supplies that do not meet the definition of a Medicare benefit.

Claims Processing Instructions

At A/B MAC and DME MAC discretion, claims submitted using the GY modifier may be auto denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

Effective for dates of service on and after July 1, 2011, A/B MACs shall automatically deny claim line(s) items submitted with a GZ modifier. A/B MACs shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their websites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review.

20.9.3 – Appeals

(Rev.13216; Issued:05-09-2025; Effective: 06-03-2025; Implementation:06-03-2025)

When a request for review is received as a result of an initial determination based on a correct coding initiative edit, and after determining that the reviews were coded correctly, the reviewer must come to the same conclusion as the initial determination (i.e., the review does not result in an increase in payment). If the review determines that a correct coding modifier not submitted with the initial claim could have been appended to either code of an edit code pair, the reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of "1." If the correct coding initiative edit modifier indicator is a "0," the reviewer must come to the same conclusion as the initial determination. If the conclusion is the same as the initial determination, the review determination must repeat the generic language that appears in the Medicare Summary Notice (MSN) or remittance advice notice pertaining to the

correct coding edit. In addition, MACs must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for MACs in the Medicare NCCI Correspondence Language Manual on the Medicare NCCI Edits webpage.

- 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." The 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.