JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.014
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	Subject **NCCI and MUE Edits**	*Supersedes Date*	09/01/2019
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This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Priority Partners	US Family Health Plan

Keywords: MUE, NCCI, PTP

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

Accurate coding and reporting of services is a critical aspect of assuring proper payment. CMS developed the National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment for applicable claims. Consistent with CMS, JHHP aligns with the NCCI program coding policies which are based on coding conventions defined in the AMA's "Current Procedural Terminology (CPT) Manual," Medicaid and Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. This policy applies to all practitioners (participating and non-participating), hospitals, providers, or suppliers eligible to bill relevant HCPCS/CPT codes to JHHP on a CMS-1500 or CMS-1450 or their electronic equivalents.

III. POLICY STATEMENT

The CMS MUE and NCCI program coding and reimbursement methodologies have been adopted by JHHP to reduce improper payments for applicable services billed by a single provider/supplier for a single patient on the same date of service. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. This policy applies to Inpatient/Outpatient facilities, physicians and other healthcare providers and Durable Medical Equipment Prosthetic and Orthotic Service (DMEPOS) suppliers who submit claims to JHHP for reimbursement on a CMS-1500 or UB-04/CMS-1450, or their electronic equivalents.
2. JHHP will not reimburse charges that are inconsistent with NCCI and MUE policies and guidelines.
3. JHHP receive quarterly updates to NCCI edits, from CMS, indicating the version and the effective date. CMS makes all decisions about the contents of the NCCI program, edits and its policies.
4. NCCI edits do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers/suppliers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.
5. The NCCI program includes 3 types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code (AOC) Edits. Guidance for the NCCI program and these edits, along with other additional information sources are found on the CMS NCCI Website.
6. Since NCCI PTP edits are applied to same-day services by the same provider/supplier to the same member, certain Global Surgery Rules are applicable to the NCCI program.
7. Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Providers/suppliers must not unbundle or separately report for services that can be described by a more appropriate HCPCS/CPT code.

8. Providers who report a code with units greater than the MUE value assigned, the line and/or claim will deny.
9. NCCI claim edits do not supersede the necessity to obtain a referral or preauthorization. Providers are responsible to verify the individual member's contract for specific plan benefits and to obtain a prior authorization/reauthorization before an item, procedure or service is rendered, if required.
10. To reduce the number of claims denied for NCCI gender-specific procedure edits, use the KX modifier to show services for transgender, ambiguous genitalia, and intersex patients. If an NCCI gender-specific procedure edit conflict occurs, the KX modifier alerts JHHP that it isn't an error and allows the claim to continue processing.

V. CORRECT CODING MODIFIER INDICATORS (CCMI) and HCPCS MODIFIERS

1. The use of modifiers that are not NCCI PTP-associated modifiers shall not bypass an NCCI PTP edit.
   a. 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. Refer to JHHP's Anatomic Modifier policy for additional guidance.
2. 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.
3. Physician or non-physician provider must perform all services noted in the HCPCS/CPT descriptor unless descriptor states otherwise.
4. The NCCI File Formats include a CCMI for the Column One / Column Two Correct Coding edit file. This indicator determines whether an NCCI PTP-associated modifier causes the code pair to bypass the edit. The CCMI will be either a "0," "1," or a "9".
5. All line items for the same patient, 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.
6. 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.
7. 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 one of the codes indicating the reason to bypass the edit.

VI. EXCEPTIONS and EXCLUSIONS

1. Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.
2. NCCI does not apply to the Hospital Inpatient Prospective Payment Systems (IPPS).
3. **PPMCO:** JHHP will process and reimburse claims in accordance with Maryland Medicaid guidance and the CMS Medicaid NCCI program guidance. Please consult the authoritative guidance found in the Maryland Medicaid and CMS websites to obtain additional specific information on policy, benefits, and coverage not addressed in this policy.
   a. Federal law and CMS guidelines require all state Medical Assistance programs to adopt NCCI edits as part of their respective payment methodologies.
   b. In accordance with MDH guidance, services must be rendered within the limitations of Medicaid, Medicare and NCCI guidelines. JHHP will deny claims when coding conflicts with NCCI edits.
   c. In alignment with the Maryland Department of Health (MDH), JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.

d. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
   - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

4. **USFHP:** JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this policy.

VII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Add-on Code (AOC) Edits	AOC edits consist of a listing of HCPCS and CPT Add-on Codes with their respective primary codes. 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.
Column One/Column Two Correct Coding Edit Tables	Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider/supplier reports the 2 codes of an edit pair, the Column Two code is denied, and the Column One code is eligible for payment. However, if it is clinically appropriate to use an NCCI PTP-associated modifier, both the Column One and Column Two codes may be eligible for payment, when used correctly. **Column 1**: Comprehensive or major code **Column 2**: Secondary or component code

Hospital (Outpatient hospital and other facilities) PTP Edits	Hospital PTP edits apply to Types of Bills (TOBs) subject to the Outpatient Code Editor (OCE) for the Outpatient Prospective Payment System (OPPS). These edits apply to outpatient hospital services and other facility services, including therapy providers in Part B Skilled Nursing Facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy and speech language pathology providers (OPTs), and certain claims for home health agencies (HHAs) billing under TOBs 22X, 23X, 75X, 74X, 34X. Hospital PTP code pair tables work the same as the practitioner PTP code pair tables. Modifiers and coding pairs may differ from the practitioner PTP code pair tables because of differences between facility and professional services.
Medically Unlikely Edits (MUEs)	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 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 patient, on a single date of service.
Mutually Exclusive Procedures	Certain services or procedures would not reasonably be performed at the same session by the same provider on the same patient.
Practitioner PTP Edits	Practitioner PTP code pair edits apply to physicians and Ambulatory Surgery Center (ASC) claims. Each edit has a Column One and Column Two HCPCS/CPT code.
Procedure-to-Procedure (PTP) Edits	The purpose of the NCCI PTP edits is to prevent improper payment when incorrect code combinations are reported. PTP code pair edits are automated prepayment edits that prevent improper payment when you report certain codes together for covered services. If a provider/supplier reports the 2 codes of an edit pair for the same patient on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.

Modifiers

Modifier	Definition

KX	Requirements specified in the medical policy have been met.
NCCI PTP-associated modifiers	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

Correct Coding Modifier Indicators

CCMI	Definition
0	An NCCI PTP-associated modifier is **not** allowed and will **not** bypass the edit.
1	An NCCI PTP-associated modifier is allowed and will bypass the edit.
9	The use of NCCI PTP-associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator prevents blank spaces from appearing in the indicator field.

MUE Adjudication Indicator (MAI)

MAI	Definition
1	MUEs for HCPCS codes with an MAI of “1” will be adjudicated as a claim line edit. An MAI of 1 may require modifiers to distinguish repeat services or anatomic differences.
2	CMS establishes edits with an MAI of 2 based directly on regulation, statute or subregulatory guidance, description of HCPCS/CPT code, or coding guidance. MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because units of service (UOS) on the same date of service in excess of the MUE value would be considered contrary to statute, regulation, or subregulatory guidance. CMS gives no instances in which a higher value would be correct and payable. The expectation is the provider will not bill above allowable MUE.

3	MUEs for HCPCS 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, JHHP may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units.

VIII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 13- Radiology Services and Other Diagnostic Procedures
- Medicare Claims Processing Manual CH. 23- Fee Schedule Administration and Coding Requirements
- Medicare National Correct Coding Initiative (NCCI) Tools
- MLN901346: How To Use The Medicare NCCI Tools
- NCCI for Medicaid | CMS
- NCCI for Medicare | CM
- TRICARE Reimbursement Manual

IX. APPROVALS

Date	Review/Revision	Approved By
7/5/2024	Updated policy format Policy language revised Informational tables added References updated	Reimbursement Policy Committee (RPC)