

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10233	Date: July 24, 2020
	Change Request 11782

Transmittal 10136, dated May 15, 2020, is being rescinded and replaced by Transmittal 10233, dated, July 24, 2020, to revise section 20.9 header, the acronym is being changed from CCI to NCCI to include the letter N. In section 20.9.6, add the entire section from the file which is attached on the Transmittals page, back on to the web page. All other information remains the same.

SUBJECT: Update to the (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements

I. SUMMARY OF CHANGES: This Change Request (CR) will update the Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements.

EFFECTIVE DATE: June 16, 2020

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 16, 2020

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 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers
R	23/20.9.1.1 - Instructions for Codes with Modifiers (A/B MACs (B) Only)
R	23/20.9.3 - Appeals
R	23/20.9.3.1- Procedure-to-Procedure Edits
R	23/20.9.3.2- Medically Unlikely Edits
R	23/20.9.6 - Correct Coding Edit (CCE) File Record Format

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: 10233	Date: July 24, 2020	Change Request: 11782
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SUBJECT: Update to the (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements

EFFECTIVE DATE: June 16, 2020

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IMPLEMENTATION DATE: June 16, 2020

I. GENERAL INFORMATION

A. Background: This change request will update the Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11782.1	Medicare Administrative Contractors (MACs) shall refer to IOM Pub 100-04, Chapter 23, Section 20.9 for information on the National Correct Coding initiative (NCCI), new updates.		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	D M E	C E D

		A	B	H H H	M A C	I
	None					

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

V. CONTACTS

Pre-Implementation Contact(s): Amin Koraganie, 410-786-9615 or amin.koraganie@cms.hhs.gov , Valeria Allen, 410-786-7443 or valeria.allen@cms.hhs.gov

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

VI. 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. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

The CMS developed the National Correct Coding Initiative (NCCI) 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 both the Procedure-to-Procedure (PTP), Medically Unlikely Edits (MUEs), Add-on Code (AOC) Edits and additional information sources *are* found on the following CMS [NCCI Website at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index)

The National Correct Coding Initiative Policy Manual for Medicare Services (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 Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services.

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 Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code is the maximum units of service that a provider *or supplier* would report under most circumstances for a single beneficiary on a single date of service.

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 [NCCI Website](#) for *use* by the Medicare Contractors to answer routine correspondence inquiries about the NCCI procedure- to- procedure (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 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers

(Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

The National Correct Coding File Formats continue to include a Correct Coding Modifier Indicator (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." The definitions of each are:

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*.

20.9.1.1 - Instructions for Codes with Modifiers (A/B MACs (B) Only)

(Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

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 procedure-to-procedure (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 two 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.

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 -X{EPSU}”

Modifiers 59 or -X{EPSU} 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-associated modifier that is used. Find further information on Modifier 59 in the Coding Policy Manual available on the CMS website.

Examples of appropriate use of modifiers 59 and -X{EPSU} can be found in [SE1418, Proper Use of Modifier 59](#).

1. Modifiers 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.
2. Modifiers 59 or XE are used appropriately when the procedures are performed in different encounters on the same day.
3. Modifiers 59 or -X{EPSU} are used inappropriately if the basis for its use is that the narrative description of the two codes is different.
4. Other specific appropriate uses of modifiers 59 or -XE
There are three other limited situations in which two 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. Modifiers 59 or -XE are used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 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 two-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. Modifiers 59 or -XU are 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 non-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. Modifiers 59 or -XU are 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.

Use of modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59.

Modifier “-59” shall not be used with the following codes:

77427 Radiation treatment management, five treatments

Evaluation and management services

When a provider *or supplier* submits a claim for any of the codes specified above with the “-59” modifier, the A/B MAC must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.A above, A/B MACs shall convey additional messaging.

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. 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 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 *found on the CMS website at: [MLN Booklet: Medicare Advance Written Notices of Noncoverage ICN 006266](#)*

Use of the A9270

A9270, Noncovered 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 NOC code available, the 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 Web sites, 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. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

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 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 *Correspondence Language Manual on the CMS NCCI Website at: <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index>*.

20.9.3.1- Procedure-to-Procedure Edits

(Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

All PTP edits have a “Correct Coding Modifier Indicator” (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 Correspondence Language Manual for Medicare Services.

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-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 Correspondence Language Manual for Medicare Services.

20.9.3.2- Medically Unlikely Edits

(Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

All HCPCS codes with MUE values have an “MUE adjudication indicator” or “MAI”.

MUEs for HCPCS codes with an MAI of “1”:

MUEs for HCPCS codes with an MAI of “1” will be adjudicated as a claim line edit.

MUEs for HCPCS codes with an MAI of “2”:

MUEs for HCPCS codes with an MAI of “2”: 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 UOS on the same date of service (DOS) 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 CMS and National Correct Coding Initiative Policy manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same DOS 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 codes with an MAI of “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, 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 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/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS 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 Advance Beneficiary Notice (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 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 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) UOS. For specific instructions for Ambulatory Surgical Centers, refer to Chapter 14, Section 40.5 of the "Medicare Claims Processing Manual" *on the CMS website at: [Regulations-and-Guidance.Ch14](#)*

When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two 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 Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" *on the CMS website at: [Regulations-and-Guidance.Ch34](#)*

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 Correspondence Language Manual for Medicare Services.
- 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 Healthcare Common Procedure Coding System code.
- 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 National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.

20.9.6 - Correct Coding Edit (CCE) File Record Format

(Rev. 10233; Issued: 07-24-20, Effective: 06-16-20, Implementation: 06-16-20)

The following record layout for the Correct Coding Edit (CCE) File is available to the Shared Systems, A/B MACs (B), and the Regional Offices via Network Data Mover and CMS Data Center.

A/B MAC (B)/Shared Systems Record Format

Field	Type	Record Position	Length
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	1	5
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	6	5
Prior Rebundled Code Indicator “*” rebundled prior to 1996 edits “•” rebundled 1/1/1996 or later	Character	11	1
Correspondence Language Reference	Character	12	12
Effective Date (4 position year followed by Julian day)	Numeric	24	7
Deletion Date (4 position year followed by Julian day)	Numeric	31	7
Modifier Indicators “0” No CCE modifier allowed “1” CCE modifier acceptable “9” Use of CCE modifier not specified	Numeric	38	1
Savings Type Indicator Edit “1” CCE	Character	39	1

Field	Type	Record Position	Length
"2" Mutually Exclusive			