BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

CLAIMSXTEN

Correct Coding Initiative

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INTRODUCTION

Accurate coding and reporting of services on medical claims submitted to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan is critical in assuring proper payment to providers. On March 2, 2019, all BlueCross and BlueChoice® lines of business upgraded their code-auditing system from ClaimCheck® to ClaimsXtenTM, Change Healthcare's next-generation solution for ensuring proper coding on health insurance claims.

The upgrade to ClaimsXten allows BlueCross to better validate claims-coding accuracy and more closely align claims adjudication with medical policies, benefit plans and the Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI). The purpose of NCCI is to control improper coding leading to incorrect payment for medical claims.

For providers, implementation of the ClaimsXten software means correct coding on claims submitted to BlueCross and BlueChoice will be more important than ever. While most of the previous ClaimCheck edits continue to exist within ClaimsXten, providers could see new edits on their remittance notices when claims are not coded in accordance with current coding practices.

In the first quarter of 2021, we implemented the second phase of ClaimsXten. Along with this implementation came additional rules to help ensure claims are being coded properly.

WHAT IS CLAIMSXTEN?

ClaimsXten is robust code-auditing software designed to ensure health insurance claims are coded properly.

The software relies on clinically supported rules and logic influenced by national medical societies, current coding practices and the NCCI.

ClaimsXten contains rules, each of which consists of the logic necessary to execute a specific payment policy or guideline. Each rule has an associated set of clinical data that, when applied, results in an edit. The edit is a recommendation to deny, review, modify or allow a specific claim line.

ClaimsXten simplifies payment rules and analyzes claims in the context of claims history. It offers enhanced analysis of coding for issues such as deleted CPT® codes, unbundled services, appropriateness of procedures for age and gender, invalid modifiers, medically unlikely number of units for the same date of service, and investigational procedures.

The first phase of ClaimsXten consists of edits that apply to providers that bill professionally.

Providers will see benefits of the ClaimsXten upgrade that include:

- Improved adjudication accuracy and consistency.
- Streamlined claims adjudication.
- Fewer manual reviews.
- Enhanced payment transparency.
- Reduced appeals.
- Clinically supported rules and logic.

WHAT IS NCCI?

The ClaimsXten auditing logic better aligns BlueCross and BlueChoice claims adjudication with CMS' NCCI.

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding and incorrect payments for medical services. The coding policies are based on coding conventions defined in the American Medical Association (AMA)'s CPT manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

According to the **NCCI Policy Manual**, NCCI includes three types of edits: NCCI procedure-to-procedure (PTP) edits, medically unlikely edits (MUEs) and add-on code edits.

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary 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-associated modifier is also reported.

MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

CLAIMSXTEN RULES — PHASE I

These rules include a description and an example of how each rule is applied. Some examples include procedure codes that do not represent all applicable coding. Procedure codes are updated periodically, and the coding referenced is current and valid as of the date of this publication.

Rule	Description	Example
CMS Correct Coding Initiative	This rule recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in NCCI.	When procedure code 0213T (injection with ultrasound guidance) (Column Two code) is submitted with 19304 (mastectomy) (Column One code), procedure code 0213T is recommended for denial.
Unbundling	This rule recommends the denial of claim lines where a procedure is submitted with another procedure that is one of the following: a more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service.	Procedure code 49000 (exploratory laparotomy) is recommended for denial when submitted with procedure code 44010 (duodenotomy, exploration biopsy).
Allowed Once per Date of Service	This rule recommends the denial of claim lines containing procedure codes that should only be performed once per date of service.	Bilateral tenotomy procedure 27392 is recommended for denial if submitted more than once on the same date of service.
Medicare MUE Durable Medical Equipment (DME)	This rule checks for the line quantity billed on a claim line and recommends denial if the line quantity exceeds the MUE for the HCPCS/CPT code with an MUE adjudication indicator (MAI) of 1, 2 or 3 reported by the same provider or across providers (depending on the provider setting configuration) for the same member on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not.	A claim is submitted for A4235 (replacement battery, for use with home blood glucose monitor) with seven units across three days. The line quantity is spread across the three days to determine the quantity per day: 7 units/3 days = 2.33 per day. The total is rounded to the nearest whole number, 2. The MUE for A4235 is 2, and the MAI is 1. Only this line is considered, and the daily value is equal to the MUE allotted. Therefore, the line will be allowed.
Allowed Multiple Times per Date of Service	This rule recommends the denial of claim lines when the quantity billed for the procedure code exceeds the maximum allowed per date of service.	Procedure 29125 (for short arm splint application) has a maximum allowance of twice per date of service. If the submission of the procedure is three times, the third occurrence is recommended for denial.
CMS Always Bundled Procedures	This rule recommends the denial of claims containing lines with procedure codes indicated by CMS as always bundled when billed with any other procedure not indicated as always bundled for the same member, the same provider and for the same date of service.	Procedure code 36416 (collection of blood specimen) is identified by CMS as a bundled service. When this procedure is submitted with another procedure that is not considered a bundled service (for example, 33510, coronary artery bypass), 36416 is recommended for denial.
Base Code Quantity	This rule recommends the denial of claim lines containing base codes billed with a quantity greater than one per date of service.	When procedure code 63102 (vertebral body resection) is submitted more than once for the same date of service, and no other line on the same claim or in history, the line is recommended for denial and replaces procedure code 63102 with a quantity of 1.

Rule	Description	Example
New Patient Code for Established Patient	This rule recommends the denial of claim lines containing a new patient E&M code for established patients.	New patient code 99204 is recommended for denial when submitted within three years (by the same provider or provider group/specialty) of another E&M code. It is replaced with the appropriate established patient code as indicated in the new patient crosswalk.
Same-Day Visit	This rule recommends the denial of claim lines with E&M codes billed on the same date of service as a procedure code within a global period.	E&M procedure code 99213 is recommended for denial when submitted on the same date of service as procedure code 49000.
Bilateral	This rule identifies the same code billed twice for the same date of service where the first code has the bilateral -50 modifier appended. The rule recommends the denial of the second submission regardless if submitted with or without a bilateral modifier.	When myringotomy procedure code 69420 is submitted twice and at least one of the lines has modifier -50, the line without the modifier -50 (or the second line with modifier -50) is recommended for denial.
Postoperative Visit	This rule recommends the denial of claim lines containing E&M codes billed within the postoperative period.	E&M procedure code 99213 is recommended for denial when submitted within the 90-day postoperative period of procedure code 49000.
Co-Surgeon	This rule identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have not met the criteria for submitting a procedure for co-surgery payment according to CMS.	Procedure A4890-62 is recommended for denial, as this procedure does not warrant co-surgeons according to CMS.
Preoperative Visit	This rule recommends the denial of claim lines containing E&M codes billed within the preoperative period.	E&M procedure code 99213 is recommended for denial when submitted within the one-day preoperative period of procedure code 49000. The diagnosis code is the same on the claim line for both procedures.
Medicare MUE — Practitioner	This rule recommends the denial of claim lines where the MUE for a CPT/HCPCS code is exceeded by the same provider for the same member on the same date of service. Procedure codes with an MAI of 1 will edit as a single line edit. Procedure codes with an MAI of 2 or 3 will consider frequency from other claim lines to determine if the MUE is met or exceeded. This rule will evaluate date ranges to determine if the MUE has been met or not.	A provider submits a claim with procedure code 11771 (excision of pilonidal cyst or sinus; extensive), line quantity is 2 and 2 days' time interval. This procedure code's daily MUE allowed value is 1, and the MAI is 2. The calculated individual line quantity is 1, so the current claim line will exit the rule.
Add-On Without Base Code	There are CPT- and HCPCS-defined add-on codes for which the AMA has assigned specific base code(s). This rule audits those codes and recommends the denial of claim lines containing the add-on codes when the defined base code cannot be found by the same member for the same date of service. In addition to the add-on code content in this rule, this rule also audits that vaccine supply and immune globulin supply codes are submitted with their associated administration procedure code as is required according to CPT guidelines.	CPT add-on procedure code 15787 (abrasion; each additional 4 lesions or less) is submitted without the base procedure code 15786 (abrasion; single lesion) present on the claim or in any history lines. Procedure code 15787 is recommended for denial.
Assistant Surgeon	This rule recommends the denial of claim lines containing procedure codes inappropriately submitted with an assistant surgeon modifier 80, 81, 82 or AS in any of the four modifier positions.	When procedure code 10021 (fine needle aspiration) is submitted with modifier -80, the line is recommended for denial.

Rule	Description	Example
Modifier to Procedure Validation — Payment Modifiers	This rule recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Anesthesia procedure 00560 is recommended for denial when submitted with modifier -50.
Multiple Code Rebundling	This rule recommends the denial of claim lines when a more comprehensive procedure exists. If the more comprehensive code is also submitted for this member by the same provider for the same date of service, the component codes will be denied and the comprehensive code will be recommended for reimbursement. If the more comprehensive code is not submitted for this member by the same provider for the same date of service, it will be added to the claim.	When laboratory procedures 82465 (cholesterol), 83718 (HDL cholesterol) and 84478 (triglycerides) are submitted together for the same date of service, all are recommended for denial and replaced with the panel code 80061 (lipid panel).
Global Component	This rule identifies instances where the sum of all payments (total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure. This rule audits for the same member ID, the same date of service, across providers.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by a different provider on the same date of service, 51725-26 is recommended for denial.
CMS Modifier to Procedure Validation	This rule recommends the denial of claim lines containing invalid procedure code and modifier combinations based on the CMS Physician Fee Schedule (and select DME modifiers) and the date of service.	Procedure code 51784-50 (electromyography studies of anal or urethral sphincter, other than needle) is recommended for denial, as this procedure is not valid with modifier -50.
Modifier to Procedure Validation — Nonpayment Modifiers	This rule recommends the denial of procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Hysterectomy procedure 58150 is recommended for denial when submitted with modifier -LT.
Duplicate Component Billing	This rule recommends the denial of claim lines containing procedure codes billed with a professional or technical modifier when the procedure code was previously submitted as a global procedure for the same provider ID for the same member for the same date of service.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by the same provider on the same date of service, 51725-26 is recommended for denial.
Age Code Replacement	This rule recommends the denial of claim lines containing procedure codes and preventive E&M codes that are inconsistent with the patient's age and replaces the line with the age-appropriate code.	Procedure code 42825 (tonsillectomy, younger than age 12) is replaced with procedure code 42826 (tonsillectomy, age 12 or over) when submitted for a 20-year-old patient.
Age	This rule recommends the denial of claim lines containing procedure codes inconsistent with the patient's age.	Maternity procedure code 59400 is recommended for denial when submitted for a 9-year-old patient.

CLAIMSXTEN RULES — PHASE II

Rule	Description	Example
Duplicate Line Items	This rule recommends the denial of a claim line that matches a previously submitted claim line on a different claim or the current claim. Fields that must match are the member, provider, procedure code, modifier, date of service, quantity and billed amount.	Two claims are on file for a member with the same provider, procedure code and modifier for the same date and billed amount. OR A claim is submitted with three lines, but two of the lines have the same procedure code, modifier, quantity, date of service and billed amount.
Missing Professional Component Modifier	This rule recommends the denial of a claims line containing a procedure code submitted without a professional component modifier -26 in a facility setting (POS 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56 or 61). The rule will replace the line with a new line with the same procedure code and the professional component modifier -26.	Laboratory procedure 88106 is submitted without modifier -26 with a POS of 21, 22 or 24, and this claim line is denied. The same procedure (88106) is then added to the claim with the modifier -26 appended for payment.
Obstetrics Package Rule	This rule audits potential overpayments for obstetric care. It evaluates claim lines to determine if any global obstetric (OB) care codes (defined as containing antepartum, delivery and postpartum services, i.e., 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care or delivery-only services, during the average length of time of the typical pregnancy and postpartum period as applicable, 280 and 322 days, respectively.	A claim line is submitted with global obstetrical procedure code 59400 (routine obstetric care, including antepartum care, vaginal delivery and postpartum care) on March 1, 2018. In history, global obstetrical procedure code 59400 was previously submitted on Feb. 1, 2018, for the same member and was paid. The claim line would be denied with a certainty of apply. Global obstetrical code 59400 was submitted within 322 days of this current submission of global code 59400.
Inpatient Consultations	This rule recommends the denial of claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a specified interval of time.	Inpatient consultation code 99252 was previously submitted on another claim for the same member and provider, with a claim line date of service within five days of the date for the current claim line submitted with inpatient consultation code 99253. Both claims have 250.82 as the diagnosis reported. Inpatient consultation code 99253 is denied and replaced with E&M services code 99499 (or by the crosswalk value designated in the Consultation Recoding Guide).
Ambulance Bundled Services	This rule recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary for the same date of service by the same provider and on the same claim only.	A claim has a HCPCS code for ground transport (A0428) and a non-ambulance CPT code (A4931) for the same member for the same date of service and by the same provider. Line 2 (A4931) will deny using Line 1 (A0428) as support.

Rule	Description	Example
Ambulance Modifier Procedure Validation	This rule recommends the denial of ambulance services for the following reasons: • Claim lacks an appropriate origin-destination modifier or modifier QL. • Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN). • Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers.	There are two lines of coding (A0430 and A0435, both with modifier DG) for a supplier (professional) claim. Both lines will deny, as the modifier is not appropriate for the air ambulance codes submitted.
Valid Ambulance Services	This rule recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e., mileage code and transport/service code) are required in most ambulance billing scenarios. This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin-destination modifier and institutional claim lines that lack appropriate arrangement modifiers as required.	There are two lines of coding: a mileage code (A0425) and revenue code 540, and a transport/service code (A0428) and revenue code 000 on the same claim ID. Both lines will deny, as Line 1 (A0425) has a valid mileage code but an unsupported transport/service code, and Line 2 (A0428) has an invalid transport/service code due to the revenue code.
Ambulance Frequency	This rule recommends the denial of an ambulance claim line when the frequency exceeds the allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service.	There is a single line of coding (A0428) reported for the supplier (professional) claim with the quantity of 2 units. The claim will deny, as the frequency (quantity) is exceeded for the A0428.
Local Coverage Determination Procedure to Diagnosis Coverage Note: Only applies to Medicare Advantage claims.	This rule identifies claim lines for certain procedure codes associated with a single diagnosis code/ multiple diagnosis codes or no diagnosis code, modifier, age, and frequency requirement where the procedure is not considered medically necessary or payable or has payment constraints according to local coverage determinations (LCDs).	Place of Service (POS) Check A Medicare Part B claim (POS 22) is submitted for procedure code 11055. The claim line will exit the rule since POS 22 with procedure code 11055 does not qualify for the LCD policy.
National Coverage Determination Procedure to Diagnosis Coverage Note: Only applies to Medicare Advantage claims.	This rule identifies claim lines for certain procedure codes associated with a single diagnosis code/ multiple diagnosis codes or no diagnosis code, modifier, age, and frequency requirement where the procedure is not considered medically necessary or payable, or has payment constraints according to national coverage determinations (NCDs).	Multiple Explicit Diagnoses Covered and Noncovered An inpatient facility claim (Bill Type 111) is submitted with procedure code 43645 and several claim diagnoses codes. Per NCD policy, diagnosis code G83.9 is covered, Z00.00 requires additional review, and F01.50 is not covered with procedure code 43645. The default rule will evaluate claim level diagnosis fields only for facility claims. The claim line will exit the rule since the diagnosis code G83.9 is identified as covered when submitted with procedure code 43645 according to the applicable NCD policy. This example illustrates how a single covered diagnosis code will satisfy the coverage criteria and outweigh the documentation review and noncovered recommendations.

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis Coverage: Exclusionary Lab Policy Note: Only applies to Medicare Advantage claims.	This rule recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this exclusionary policy, CMS has a defined list of ICD-10-CM codes that do not support medical necessity. Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the nonpayable conditions list. OR Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of noncovered ICD-10-CM codes for all NCD edits in the Medicare NCD Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted with a procedure code 85049 and claim diagnosis code of D23.9. The default rule will evaluate claim-level diagnosis fields only for facility claims. 85049 is denied (with certainty of apply) because diagnosis code D23.9 is in the CMS defined list of ICD-10-CM codes that do not support medical necessity. Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the nonpayable conditions list.
National Coverage Determination Procedure to Diagnosis Coverage: Inclusionary Lab Policy Note: Only applies to Medicare Advantage claims.	This rule recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this Inclusionary policy, CMS has a defined list of ICD-10-CM codes covered by the Medicare program. Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list. OR Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of noncovered ICD-10-CM codes for all NCD edits in the Medicare NCD Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted a procedure code 80074 and claim diagnosis code of K76.1. The default rule will evaluate claim-level diagnosis fields only for facility claims. 80074 is denied (with certainty of apply) because diagnosis code K76.1 is not in the CMS defined list of ICD-10-CM codes covered by the Medicare program or in the CMS defined list of noncovered ICD-10-CM codes for all NCD edits. Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list.

CLAIM ADJUSTMENT REASON CODES (CARCS)

CARCs explain how a claim or service line was processed.

Note: Phase II may have additional CARCs that apply.

Rule	Description
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
94	The claim processed in excess of charges.
95	Plan procedures were not followed.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
119	Benefit maximum for this time period or occurrence has been reached.
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
234	This procedure is not paid separately. At least one remark code must be provided. It may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.

REMITTANCE ADVICE REMARK CODES (RARCS)

RARCs provide information to explain an adjustment.

Note: Phase II may have additional RARCs that apply.

Rule	Description
M15	Separately billed services/tests have been bundled, as they are considered components of the same procedure. Separate payment is not allowed.
M144	Preoperative/postoperative care payment is included in the allowance for the surgery/procedure.
N19	Procedure code is incidental to primary procedure.
N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
N129	The code is not eligible due to the patient's age.
N182	This claim/service must be billed according to the schedule for this plan.
N362	The number of days or units of service exceeds our acceptable maximum.
N390	This service/report cannot be billed separately.
N430	The procedure code is inconsistent with the units billed.
N657	This should be billed with the appropriate code for these services.

FREQUENTLY ASKED QUESTIONS

1. Will claims with dates of service prior to the ClaimsXten Implementation date go through ClaimsXten?

   Yes, claims with dates of service prior to the March 2, 2019, ClaimsXten implementation date will be adjudicated through ClaimsXten. Edits are applied based on when claims are adjudicated.

2. Does this also apply to claims filed to Avalon?

   Yes, claims filed to Avalon may also process through ClaimsXten.

3. Will remits and Explanations of Benefits come from Change Healthcare or BlueCross?

   ClaimsXten is a product of Change Healthcare, but you will still submit claims to BlueCross and BlueChoice. We will continue to process your claims and issue remittances.

4. Will this auditing software prevent claims from getting to BlueCross' system if they are not correctly coded, or will they just be edits on the back end?

   The auditing software will not prevent claims from entering our claim system, and edits will be seen on your remittance advice.

5. Are you going to be able to see different taxonomies of physicians? Our offices are all under the same tax ID, and we get many denials even though the providers are of different specialties.

   ClaimsXten reads the billing specialty and the rendering specialty. We are able to distinguish between different specialists billing services under the same group tax ID or NPI.

6. For the New Patient Code rule, would you be checking that it was a different specialty under the same TIN?

   Yes. The rule looks to see if the patient was treated by the same rendering provider or a provider with the same specialty within the same organization.

7. I've noticed there are code combinations that were previously paid, but many are now bundling. Why is that?

   Our previous claim system was not as closely aligned with CMS' NCCI or AMA coding guidelines as ClaimsXten is today. The edits you're seeing reflect industry-standard coding practices using clinically supported rules and logic.

8. My claim denied due to the modifier not being appropriate with the procedure. What is the appropriate modifier I should use with this service?

   You should use the modifier that reflects the care given. Be sure your coding system is using the latest modifiers, and please refer to the latest coding resources.

9. If we identify errors with the edits/rules, is there a direct contact?

   If you notice any adverse trends related to ClaimsXten rules and edits, please contact your Provider Relations and Education advocate.

10. Will you indicate on the remit if and when a code is changed?

    If a code was changed due to a rule, your remittance will include a CARC/RARC to indicate a change was made.

ADDITIONAL RESOURCES

These links lead to a third-party website. The owners of these sites are solely responsible for the contents and privacy policies on their sites:

- CMS: **www.cms.gov**
- National Correct Coding Initiative Edits: **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html**
- NCCI Policy Manual Archive (downloads): **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html**
- Medically Unlikely Edits: **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html**

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