IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201036 SEPTEMBER 7, 2010

National Correct Coding Initiative

In the 1990s, the Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The correct coding policies were created based on coding conventions derived from a variety of sources, such as the American Medical Association's (AMA's) Current Procedural Terminology (CPT®[1]) Guidelines, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Medicare's NCCI has been in place for many years; providers that deliver services to Medicare recipients are likely familiar with the editing content of these coding methodologies.

Recent healthcare legislation passed into law (*H.R. 3962*) requires Medicaid programs to incorporate compatible methodologies of the National Correct Coding Initiative (NCCI) into their claims processing systems. *Section 6507 – Mandatory State Use of National Correct Coding Initiative* – of *H.R.3962* mandates that NCCI methodologies must be effective for claims filed on or after October 1, 2010. As such, the Indiana Health Coverage Programs (IHCP) will implement three basic coding concepts as required by NCCI editing requirements to the Indiana*AIM* claims processing system:

- NCCI Column I and Column II edits
- Mutually Exclusive (ME) edits
- Medical Unlikely Edits (MUE)

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NCCI-specific files and the *NCCI Policy Manual*, as well as other publications related to NCCI claim editing, are located on the CMS Web site. Providers not familiar with NCCI claim editing are encouraged to access this site for educational materials and to download NCCI Column I/II, ME, and MUE files.

General

The IHCP will apply NCCI editing of medical services billed on the CMS-1500 claim form. NCCI editing will occur on claims billed with the same date of service, same member, and same billing provider National Provider Identifier (NPI).

Claims processing and mass adjustments

On October 28, 2010, the IHCP will begin processing CMS-1500 professional claims received on or after October 1, 2010, through NCCI code editing. This includes NCCI Column I and Column II, ME, and MUE edits for professional claims.

Because the IHCP claims processing system will implement NCCI for Professional (CMS-1500) claims after October 1, 2010, and because the *Patient Protection and Affordable Care Act* mandates NCCI methodologies must be effective for claims filed on or after October 1, 2010, the IHCP will systematically mass adjust claims received on or after October 1, 2010, through the implementation date. Providers must monitor forthcoming banner articles for additional details regarding this adjustment activity.

New NCCI Explanation of Benefit (EOB) Codes

The IHCP has developed new Explanation of Benefit codes that specifically identify when a claim detail has encountered an NCCI edit or a claim that could not process through NCCI editing for an unexpected event. The following table identifies the new EOB codes and provides a detailed explanation of the EOB's purpose.

New NCCI EOB Codes

New EOB	EOB Description	Purpose of EOB
4181	Service denied due to a National Correct Coding (NCCI) edit. Go to the CMS Web site for information regarding NCCI coding policies.	This EOB identifies when a detail on a professional (CMS-1500) claim has denied for Column I/II and/or ME edit.
4183	Units of service on the claim exceed the Medical Unlikely Edit (MUE) allowed per date of service. Go to the CMS Web site for information regarding maximum number of units of service allowed for the service billed.	This EOB identifies when the units of service allowed on a claim detail exceed the MUE unit limit as defined by CMS.
4185	The claim did not process through National Correct Coding Initiative (NCCI) editing. The claim will be reprocessed or adjusted at a later date. Please monitor future Remittance Advice statements for processing activity related to this claim.	This EOB identifies when a claim could not go through NCCI editing due to an unexpected event. The claim is allowed to continue through normal processing and will be subject to a mass adjustment at a later date.
9092	The claim was subjected to NCCI editing methodologies.	This EOB identifies when a claim has gone through NCCI editing and did not encounter any Column I/II, ME, or MUE edits.

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NCCI Column I /Column II edits

When the NCCI was first established, the “Column I/Column II Correct Coding Edit Table” was termed the “Comprehensive/Component Edit Table.” Although the Column II code is often a component of a more comprehensive Column I code, this relationship is not true for many edits. In the latter type of edit, the code pair edit simply represents two codes that should not be reported together.

Example of two code types that should not be reported together

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	NCCI Editing
01	11/15/2010	11/15/2010	58260	Vaginal hysterectomy, for uterus 250 grams or less	Detail is allowed
02	11/15/2010	11/15/2010	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	Detail is denied with edit 4181 – see the EOB table for EOB description

Mutually Exclusive Edits

Many procedure codes cannot be reported together because they are mutually exclusive. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or during the same patient encounter. It is critical that providers review the CMS files for ME procedure code pairs and understand that codes listed in Column I of the spreadsheet will be considered for reimbursement, and the code listed in Column II will always be the denied detail, unless an appropriate override modifier is appended.

Example of a Mutually Exclusive Edit

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	NCCI Editing
01	11/15/2010	11/15/2010	58280	Vaginal hysterectomy; with total or partial vaginectomy; with repair of enterocele	Detail is allowed
02	11/15/2010	11/15/2010	58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary (s), with repair of enterocele	Detail is denied with edit 4181 – see the EOB table for EOB description*

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Medical Unlikely Edits

A Medical Unlikely Edit for a Healthcare Common Procedure Coding System (HCPCS)/CPT code is the maximum number of units of service under most circumstances allowable by the same provider for the same beneficiary on the same date of service.

Example of incorrectly billed "From" and "To" Dates of Service

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	Units of Service Allowed*	NCCI Editing
01	11/15/2010	11/15/2010	99232	Subsequent hospital care for the evaluation and management of a patient, patient is not responding to therapy, or has a minor complication	6	Detail is **denied** with EOB 4183 (see the EOB table for EOB description)** The claim must be resubmitted with the correct units or span period of time.

* *MUE editing is based on the units of service allowed on the claim, not the units of service billed.*

** *If the dates of service were consecutive, the date span should represent the appropriate "From" and "To" period. The MUE units allowed for this code is one per day.*

Example of correctly billed "From" and "To" Dates of Service

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	Units of Service Allowed*	NCCI Editing
01	11/01/2010	11/06/2010	99232	Subsequent hospital care for the evaluation and management of a patient, patient is not responding to therapy, or has a minor complication	6	Detail is allowed and does not encounter NCCI edits. Span dates were billed appropriately.

* *MUE editing is based on the units of service allowed on the claim, not the units of service billed.*

To align with current IHCP policy, the following are exceptions to the MUE unit limit:

- A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips*: The MUE unit limit is two, and IHCP policy allows four units (or 200 test strips) per month, unless PA is obtained.
- A4259 – *Lancets, per box*. The MUE unit limit is one, and the IHCP policy allows two units per month, unless PA is obtained.
- Antepartum Care – CPT codes 59425 – *Antepartum care only; 4-6 visits*; and 59426 – *Antepartum care only; 7 or more visits* (when billed with modifiers U1 – *Trimester one – 0 through 14 weeks, 0 days*; U2 – *Trimester two – 14 weeks, one day through 28 weeks, 0 days*; or U3 – *Trimester three – 28 weeks, one day, through delivery*), and when billed on the same date of service as the lab codes listed below, will not be subject to NCCI Column I/II editing. Please refer to the *IHCP Provider Manual*, *Chapter 8*, section titled, 'Obstetrical Care,' for specific billing information and a complete list of lab services allowed for each trimester.

Antepartum care and lab services

Lab CPT Code	Lab CPT Description
81000 (includes microscopy for suspected urinary tract infection), or 81002 (without microscopy), or 81001 (Urinalysis, automated with microscopy), or 81003 (Urinalysis, automated without microscopy)	Urinalysis by dipstick, performed each visit; the use of the automated urinalysis is to be based on medical necessity as determined by the physician
86644	CMV antibody titer
86694	Herpes simplex test
86701	HIV test (optional)
86777	Toxoplasma antibody titer
88150, 88152-88155	Cervical cytology (Pap smear)
80055	Total obstetrical panel includes: • CBC with complete differential • Hepatitis B surface antigen • Rubella antibody titer • Syphilis test • Antibody screen, RBC • Blood typing (ABO) • Blood typing (RhD)
Or instead of 80055, use the following:	
85025	CBC with complete differential
87340	Hepatitis B surface antigen
86762	Rubella antibody titer
86592	Syphilis test; qualitative such as VDRL, RPR, ART
86850	Antibody screen, RBC
86900	Blood typing (ABO)
86901	Blood typing (RhD)

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The Office of Medicaid Policy and Planning (OMPP) reserves the right to make adjustments to the NCCI edits to ensure alignment with current IHCP policy.

Billing reminders

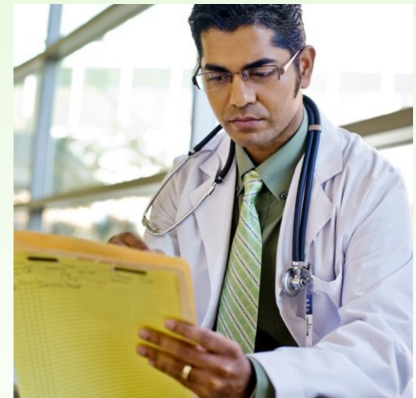
Use of modifiers

Modifiers may be appended to HCPCS/CPT codes only when clinical circumstances justify the use of the modifier. A modifier should not be appended to an HCPCS/CPT code solely to bypass NCCI editing. Please see the *NCCI Policy Manual* online for specific guidance on proper use of modifiers. The use of modifiers affects the accuracy of claims billing, reimbursement, and NCCI editing. In addition, modifiers provide clarification of certain procedures and special circumstances. Below is a summary of key modifiers used in billing and general guidance for their use:

Waiver – Claims for waiver services billed with the U7 modifier, which identifies the service as part of the Waiver Program, are currently exempt from NCCI editing.

Modifier 59 – Research shows that modifier 59 is often used incorrectly. Modifier 59 indicates that a provider performed a distinct procedure or service on the same day as another procedure or service. It identifies procedures and services that are not normally reported together, but are appropriate under the circumstances. Modifier 59 should be used only when there is no other modifier to correctly clarify the procedure or service. A distinct procedure may represent the following:

- A different session or patient encounter
- A different procedure or surgery
- A different site or organ system
- A separate incision or excision
- A separate lesion
- A separate injury or area of injury in extensive injuries



If multiple units of the same procedure are performed during the same session, the provider should report all the units on a single detail line, unless otherwise specified in medical policy.

- Modifier 50 – Bilateral procedures performed during the same operative session on both sides of the body by the same physician. The units billed would be entered as “1,” because one procedure was performed bilaterally.
- Modifier 51 – Multiple procedures or services are performed on the same day or during the same operative session by the same physician. The additional or secondary procedure or service must be identified by adding modifier 51 to the procedure or service code.
- Modifiers LT and RT – The modifiers LT (left) and RT (right) apply to codes that identify procedures that can be performed on paired organs such as ears, eyes, nostrils, kidneys, lungs, and ovaries. Modifiers LT and RT should be

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used whenever a procedure is performed on only one side to identify which one of the paired organs was operated on. The CMS requires these modifiers whenever appropriate.

Correct use of modifiers is essential to accurate billing and reimbursement for services provided. Refer to IHCP provider bulletin BT200907, dated March 6, 2009, for more information regarding correct use of modifiers. Also, listed below are some of the many resources available for obtaining additional information:

- The CMS provides carriers with guidance and instructions on the correct coding of claims and using modifiers through manuals, transmittals, and the CMS Web site.
- The National Correct Coding Initiative (NCCI) provides updates each quarter for correct modifier usage for each CPT code.

Use of span dates on the CMS-1500 claim form

Providers must be sure to always complete “From” and “To” dates, even if the service was for one single date of service. All services performed or delivered within the same calendar month and in a consecutive day pattern must be billed with the appropriate units of service and “From” and “To” period. Failure to report the correct date span and the number of units performed during the date span could result in a claim denial. Below is an example of proper use of span dates to avoid unnecessary MUE-related denials.

Proper use of date spans

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	Units of Service Allowed*	NCCI Editing
01	11/01/2010	11/5/2010	E0202	Phototherapy (bilirubin) light with photometer	5	Detail is allowed and does not encounter NCCI edits. Span dates were billed appropriately.

Claims submitted via Web interChange

Providers that submit claims via Web interChange may view those claims within two hours via the Claim Inquiry function. As a result of NCCI editing, there may be rare events when claims will not be available for viewing within the usual two-hour time frame. If the delay is longer than 24 hours, providers may contact HP Customer Assistance to determine the reason for the delay.

When performing an electronic void of a claim that was subject to NCCI auditing, providers must wait until the following day to resubmit claims related to the voided claim.

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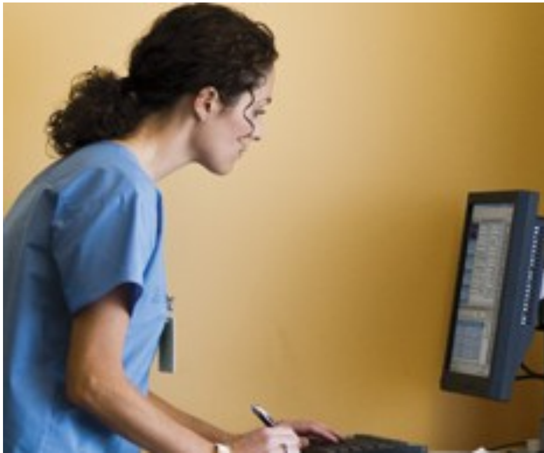

Inquiring about claim denials related to NCCI editing

Providers are encouraged to access the CMS Web site for the NCCI Column I and II, Mutually Exclusive (ME), and Medical Unlikely Edit files. These files contain specific code pairs for Column I/II and the Mutually Exclusive edits.

Providers must continue to follow the normal avenues of resolution found in the *IHCP Provider Manual* when inquiring about claims activity. It is important to note that HP's Customer Assistance team will not provide specific coding guidance with regard to NCCI editing. The team members will refer inquires to the CMS Web site.

If there are unusual circumstances in which a provider believes a claim was coded correctly and would like reconsideration of the NCCI editing, he or she must submit a formal administrative review request by completing an IHCP Programs Inquiry form or writing a letter stating the reason for disagreement with the denial or amount of reimbursement. The IHCP Programs Inquiry form can be obtained from the Forms section of the Indiana Medicaid Web site. The provider must clearly note Administrative Review on the form and attach all pertinent documentation, and add "Attention: Health Care Administrative Review Specialist."

The formal administrative review request must be filed within seven days of notification of claim payment or denial from HP:

Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263
Attn: Health Care Administrative Review Specialist

Providers with concerns about specific NCCI edits may submit comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Attention: Niles R. Rosen, M.D., Medical Director, and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

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