INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

National Correct Coding Initiative

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 11, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: December 12, 2017	Scheduled update: • Edited text as needed for clarity • Replaced the reference to *Medicaid NCCI Edit Design Manual* in the *Use of Modifiers* section with *Medicaid NCCI Technical Guidance Manual* • Removed time limitations from the *NCCI Editing of Claims Submitted via the Provider Healthcare Portal* section • Updated the description for EOB 4183 in *Table 1 – EOB Codes Related to NCCI Code Editing* • Added the *Ground Transportation Mileage* section	FSSA and DXC

Table of Contents

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and reduce improper coding, which may result in inappropriate payment of Medicare Part B and Medicaid claims. The correct coding policies were created based on coding conventions defined in the *American Medical Association (AMA) Current Procedural Terminology (CPT®[1]) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practices, and 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.

The CMS incorporated NCCI methodologies into state Medicaid programs, pursuant to the requirements of Section 6507, Mandatory State Use of National Correct Coding Initiative (NCCI), of the *Patient Protection and Affordable Care Act* (P.L. 111-148), as amended by the *Health Care and Education Recovery Act of 2010* (P.L. 111-152), together referred to as the *Affordable Care Act*, which amended section 1903(r) of the *Social Security Act*. The CMS has adopted the contents of the *National Correct Coding Initiative Policy Manual for Medicare Services*, with minor modifications for state Medicaid programs.

The Indiana Health Coverage Programs (IHCP) has implemented code auditing rules in Medicaid claim processing to represent correct coding methodologies and other coding methods based on general guidance from the CMS, the AMA, and specialty societies, as well as industry standard coding and prevailing clinical practice.

NCCI Editing and Other Coding Methodologies

As required by NCCI, the IHCP implemented two types of edits within the *Core*MMIS claim-processing system:

- **NCCI Procedure-to-Procedure (PTP) Edits** – PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column I and column II Healthcare Common Procedure Coding System (HCPCS)/CPT code. If the same provider reports the two codes of an edit pair for the same member on the same date of service, the column I code is eligible for payment but the column II code is denied.
- **Medically Unlikely Edits (MUEs)** – MUEs prevent payment for an inappropriate number or quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS), under most circumstances, reportable by the same provider for the same beneficiary on the same date of service.

The IHCP applies Medicaid NCCI methodologies of MUEs and PTP edits for the following types of services:

- Medical services billed on professional claims (applicable for practitioner and ambulatory surgical centers)
- Outpatient services in hospitals
- Durable medical equipment

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

As part of this enhanced code editing, the following code methodologies apply:

- Bilateral services billed with a unit-of-service quantity greater than one
- CPT add-on codes reported without reporting a corresponding primary procedure or service
- Evaluation and management codes billed on the same date of services as a procedure within a global period
- Evaluation and management codes billed within the pre- and post-operative period
- Component rebundling to deny claims when component codes are billed and a single comprehensive code should be billed

> *Note: Outpatient claims are subjected to component rebundling. The edit will post and deny when multiple component codes are billed, but a single comprehensive code should have been billed instead.*

NCCI editing applies to services on the same date of service, for the same member, by the same provider, on the same or different claims. "Same provider" refers to the same rendering provider (or billing provider, when there is no unique rendering provider), as indicated by the National Provider Identifier (NPI) billed. When more than one rendering provider delivers services to a member on the same date of service, the claim should reflect the different providers' NPIs at the claim detail level, if applicable. When mid-level practitioners bill under the NPI of a physician, the NCCI edits continue to apply. In some instances, when a single provider delivers more than one service to a member on the same date of service, a procedure code modifier can be used to indicate that the service is separate and distinct and to allow the claim to bypass the NCCI editing. In other instances, use of a modifier is prohibited. See the *Use of Modifiers* section for more information.

For explanation of benefits (EOB) codes related to NCCI, see the *NCCI Code Editing Explanation of Benefits Codes* section of this module. To appeal NCCI editing of a claim, providers must follow the procedures outlined in the *Claim Administrative Review and Appeals* module.

Medicaid-specific NCCI files and Medicaid NCCI reference documents are located on *The National Correct Coding Initiative in Medicaid* page at medicaid.gov. Providers not familiar with NCCI methodology are encouraged to access this site for educational materials and to download NCCI PTP and MUE files. Providers may submit questions regarding NCCI editing to the following address or fax number:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

Fax: (317) 571-1745

> *Note: Providers should not send claim or appeal questions to this address.*

Use of Modifiers

When a single rendering provider delivers more than one service to a member on the same date of service, the provider may append an appropriate modifier on the claim to indicate that the service is separate and distinct if the following applies:

- Use of the modifier is allowed per NCCI guidelines.
- The medical record includes sufficient evidence to support use of the modifier.

If use of a modifier is not allowed, the provider should bill the predominant service performed, as described in national billing guidelines.

Modifiers may be appended to CPT or HCPCS codes only when clinical circumstances justify the use of the modifier. A modifier should not be appended to a CPT or HCPCS code solely to bypass NCCI editing. See the *Medicaid NCCI Technical Guidance Manual* on *The National Correct Coding Initiative in Medicaid* page at medicaid.gov for 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. Correct use of modifiers is essential to accurate billing and reimbursement for services provided.

See the *Claim Submission and Processing* module for more information regarding the correct use of modifiers.

Use of Span Dates on Professional Claims

All services performed or delivered within the same calendar month and in a consecutive day pattern (or within a single day) must be billed with the appropriate units of service and *from* and *to* dates (*span dates*). Failure to report the correct date span and the number of units performed during the date span could result in a claim denial. For examples of the proper use of span dates to avoid unnecessary MUE-related denials, see *Billing Guidance for Dates of Service* in *Section 3: CMS-1500 Claim Form Completion and 837P Transaction Instructions* in the *Claim Submission and Processing* module.

NCCI Editing of Claims Submitted via the Provider Healthcare Portal

Providers that submit claims via the IHCP Provider Healthcare Portal may view those claims via the Search Claims function. As a result of NCCI editing, there may be rare events when claims will not be immediately available for viewing. If the delay is longer than 24 hours, providers may contact Customer Assistance at 1-800-457-4584 to determine the reason for the delay.

Claim Processing and Auto Recoupments

NCCI code editing methodologies can result in auto recoupments for MUEs or PTP edits, such as when a provider incorrectly bills more than the maximum units of service established for a procedure or when a column II code is reimbursed prior to the column I code.

NCCI and Code Editing Explanation of Benefits Codes

The IHCP developed EOB codes that specifically identify when a claim detail has encountered an NCCI code edit or when a claim could not process through NCCI code editing for an unexpected event.

Table 1 – EOB Codes Related to NCCI Code Editing

EOB	EOB Description	Purpose of EOB
4183	Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service. Go to http://www.medicaid.gov/nationalcorrectcodinited/ for information regarding maximum number of units of service allowed for the service billed.	This EOB identifies when a detail on a professional or outpatient claim has denied for an MUE.
4186	This is a component of a more comprehensive service. Please resubmit claim with the procedure code that most comprehensively describes the service performed.	This EOB identifies when multiple procedure codes are unbundled, and a single comprehensive code should have been billed. This edit applies to laboratory procedures within the 80000–89999 range only.
6382	Routine preoperative medical visits performed on the day of surgery are not separately payable. Documentation not present or not sufficient to justify care was of a non-routine nature.	This EOB identifies denied claim details when an evaluation and management procedure code is billed on the same date as a surgery that has a global period of 0, 10, or 90 days.
6384	Routine preoperative medical visits performed within one day prior to surgery are not separately payable. Documentation not present or not sufficient to justify care was of a non-routine visit.	This EOB identifies denied claim details when an evaluation and management procedure code is billed within the pre-operative period, which is one day before a surgery that has a 90 day global period. Codes with 0- or 10-day global surgery periods are considered minor surgical procedures and are not subject to this rule.
6386	Postoperative medical visits performed within 90 days of surgery are payable only for a surgical complication and if documented as medically indicated. Documentation not present or does not justify the visit billed.	This EOB identifies denied claim details when an evaluation and management procedure code is billed during the 90 day post-operative period. See the Medicare Physician Fee Schedule at cms.gov to determine the global period for a procedure code.
6387	Post operative medical visits performed within 0-10 days of surgery are payable only for a surgical complication and if documented as medically indicated. Documentation not present or does not justify the visit billed.	This EOB identifies denied claim details when an evaluation and management procedure code is billed during the 0 or 10 days post-operative period. See the Medicare Physician Fee Schedule at cms.gov to determine the global period for a procedure code.
6390	Add-on codes are performed in addition to the primary service or procedure and must never be reported as a stand-alone code.	This EOB identifies denied claim lines when an add-on code is billed without the primary service/procedure (base code) for the same member, on the same date of service, by the same provider, on the same claim or across claims in history.
6396	The service is not payable with another service on the same date of service due to National Correct Coding Initiative.	This EOB identifies when a detail on a claim has denied for a PTP edit.
6399	A previously paid service is being recouped per National Correct Coding Initiative (NCCI) processing of another service on the same date of service by the same provider.	This EOB identifies previously paid claim details that are being recouped based on NCCI processing guidelines.

State-Specific Units of Service (Deactivated Edits)

The NCCI, under the federal *Patient Protection and Affordable Care Act* (H.R. 3590, Section 6507), requires state Medicaid programs to include "NCCI methodologies" in their claim-processing systems. In certain cases, states will request the deactivation of an edit when the state has state-specific regulations or payment policies. An NCCI edit is either a PTP code pair or an MUE that has a specific unit of service identified for the procedure code. When the state has state-specific unit-of-service edits or PTP edits that are different from the NCCI edits, these edits are known as *deactivated edits*. The following sections describe deactivated edits or situations.

Applied Behavior Analysis Therapy

Applied behavior analysis (ABA) therapy is covered for the treatment of autism spectrum disorder (ASD) for members 20 years of age and younger. See the *Mental Health and Addiction Services* module for information regarding coverage and billing for ABA therapy.

The IHCP provides reimbursement when the services are specified as direct ABA services and are provided by a qualified service provider. Providers must bill one of the procedure codes listed in the *Procedure Codes for Applied Behavioral Analysis Therapy* table in *Mental Health and Addiction Services Codes* on the *Code Sets* page at indianamedicaid.com. Providers must bill the procedure codes with the appropriate U1, U2, or U3 modifier to indicate that the services are for ABA therapy, as well as to specify the educational level of the rendering provider.

The IHCP restricts the allowable number of units for procedure codes 96150–96155 when these codes are billed *without* an appropriate ABA therapy modifier.

- Claims processed in *Core*MMIS for procedure codes 96150, 96153, and 96154 ***without*** an appropriate ABA therapy modifier are limited to eight units, per the NCCI Practitioner MUE.
- Claims processed in *Core*MMIS for procedure codes 96151, 96152, and 96155 ***without*** an appropriate ABA therapy modifier are limited to six units, per the NCCI Practitioner MUE.

Fee-for-service (FFS) claims billed for codes 96150, 96151, 96152, 96154, or 96155 along with the appropriate ABA modifiers will not deny for the Practitioner MUE edit. FFS claims billed for procedure code 96153 – *Health and behavior intervention, each 15 minutes, face-to-face; group* that exceed the Practitioner MUE limit of eight units will deny for EOB 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service*, even if the appropriate ABA modifier is used. Providers receiving this denial may submit a request for an administrative review to allow the claim to pay.

Ground Transportation Mileage

With CMS approval, the IHCP has deactivated the MUE for HCPCS code A0425 – *Ground mileage, per statute mile* in excess of 250 units. This deactivation is retroactive to the edit's effective date of October 1, 2016. All other IHCP coverage and billing guidance for this code remains unchanged; see the *Transportation Services* module for details.