IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201101 FEBRUARY 15, 2011

National Correct Coding Initiative Implementation Institutional Outpatient Claims

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 should be familiar with the requirements of the CMS coding methodologies.

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 with a date of service on or after October 1, 2010. As such, the Indiana Health Coverage Programs (IHCP) will implement the NCCI methodologies into the Indiana*AIM* claims processing system. In general, there are two types of NCCI edits: the NCCI procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current

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Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and Medically Unlikely Edits (MUE), units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

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 at http://www.cms.gov/NationalCorrectCodInitEd/. Providers not familiar with NCCI claim editing are encouraged to access this site for educational materials and to download NCCI Column I/II, Mutually Exclusive (ME), and Medically Unlikely Edit (MUE) files.

General

The IHCP will apply NCCI editing to outpatient facility services billed via the UB-04 claim form or the 837P transaction. For procedure-to-procedure edits, NCCI editing will apply to services reported for the same date of service, same member, and same billing provider National Provider Identifier (NPI). Medically Unlikely Edits will be applied to single dates of service or to multiple dates of service when span dates are present on the claim. This includes bill types 13X, 71X, 73X through 79X, and 83X through 89X. Providers will be notified if additional bill types are added or removed from these edits. Also included will be claims with third party liability payments or denials. Medicare crossovers will be excluded from the NCCI editing at this time.

Claims processing and mass adjustments

On April 1, 2011, the IHCP will begin processing outpatient (UB-04) claims with dates of service on or after October 1, 2010, through NCCI code editing. This includes NCCI Column I and Column II, ME, and MUE edits for Institutional outpatient (UB-04) claims.

Because the IHCP claims processing system will implement NCCI for outpatient UB-04 claims with dates of service on or after October 1, 2010, and because the *Patient Protection and Affordable Care Act* mandates NCCI methodologies must be effective for claims with dates of service on or after October 1, 2010, the IHCP will systematically mass adjust claims with dates of service on or after October 1, 2010, through the implementation date. Providers should monitor forthcoming banners, bulletins, and newsletter 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 due to an unexpected event. The table on the next page identifies the new EOB codes and provides a detailed explanation of the EOB's purpose.

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New NCCI EOB codes

New EOB	EOB Description	Purpose of EOB
4182	Service denied due to a National Correct Coding (NCCI) edit. Go to the CMS Web site for more information regarding NCCI coding.	This EOB identifies when a detail(s) on an out-patient UB-04 claim has denied; applicable to Column I/II and ME edits.
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.

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 for a variety of reasons.

Example of two code types that should not be reported together

Line Number	Date of Service	Revenue Code	Procedure Code	Description	NCCI Editing
01	11/15/2010	360	58260	Vaginal hysterectomy, for uterus 250 grams or less	Detail is allowed
02	11/15/2010	360	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral	Detail is **denied** with edit 4182*

** See the EOB table for EOB description.*

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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 1 of the spreadsheet will be considered for reimbursement.

Example of a mutually exclusive edit

Line Number	Date of Service	Revenue Code	Procedure Code	Description	NCCI Editing
01	11/15/2010	360	58280	Vaginal hysterectomy; with total or partial vaginectomy; with repair of enterocele	Detail is allowed
02	11/15/2010	360	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 4182*

** See the EOB table for EOB description.*

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 allowable on a daily basis under most circumstances.

Example of incorrectly billed units of service

Line Number	Date of Service	Revenue Code	Procedure Code	Description	Units of Service Billed	Units of Service Allowed*	NCCI Editing
01	11/15/2010	320	71110	Radiologic examination, ribs, bilateral, 3 views	3	1	Detail is **denied** with EOB 4183**

**MUE editing is based on the units of service allowed on the claim, not the units of service billed.*
*** See the EOB table for EOB description.*

Billing reminders

Use of modifiers

Modifiers may be appended to HCPCS/CPT codes only when clinical circumstances justify the use of the modifier. It is imperative that the outpatient facility (UB-04) claims incorporate the correct use of modifiers. A modifier should not be appended to an HCPCS/CPT code solely to bypass NCCI editing. The use of modifiers affects the accuracy of claims billing, reimbursement, and NCCI editing. If multiple units of the same procedure are performed during the same session, the provider should roll all the units to a single line, unless otherwise specified in medical policy.

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In addition, modifiers provide clarification of certain procedures and special circumstances. Please refer to bulletin BT200907 for assistance in modifier use. Additional resources and information related to the proper use of modifiers is available through the American Medical Association and the Centers for Medicare & Medicaid Services Web site.

Modifier 50

Modifier 50 is used for bilateral procedures performed during the same operative session on both sides of the body by the same physician. At a minimum, modifier 50 must be appended to a CPT code when 1) a bilateral procedure is performed and 2) when CPT instructs providers to report that bilateral procedure with the use of modifier 50. In these circumstances providers should append modifier 50 to the appropriate unilateral code on one single detail on the UB-04, and bill one (1) unit of service.

When modifier 50 is appended to a procedure code, the system will recognize this as a bilateral procedure and apply the Ambulatory Surgical Center (ASC) pricing methodology for outpatient claims appropriately by processing a payment of 150 percent for the bilateral procedure. If more than one (1) unit of a bilateral service is reported on claim details where modifier 50 is not present, the claim detail could encounter an NCCI MUE edit.

> **Example**: A physician removes impacted cerumen from both ears, CPT 69210 – *Removal of impacted cerumen (separate procedure), one or both ears*. Modifier 50 would not be appropriate since the procedure is inherently bilateral. The claim detail will include one (1) unit of service to identify both ears were treated.
>
> **Example**: A physician performs a bilateral inguinal hernia, CPT 49500 – *Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible*. CPT instructions require the use of modifier 50 for this code when reporting a bilateral service. The claim detail will include modifier 50 and one (1) unit of service to identify the service was performed bilaterally during the same operative session.

Modifier 59

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

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Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. Additional information regarding the correct use of modifier 59, including examples, is available at http://www.cms.gov/MedicaidNCCICoding/05_Modifier%2059%20Article.asp#TopOfPage.

Modifier 91

This modifier is used to report repeat laboratory tests on the same day to obtain subsequent (multiple) test results. This modifier is not used when tests are performed additional times to confirm initial results or because of testing problems with specimens or equipment. Also, this modifier is not used for any other reason when a normal, one-time, reportable result is all that is required; or when other codes describe a series of test results.

> **Example**: A patient is treated for low potassium. A potassium test is run initially, before treatment begins. After treatment, the physician orders three more potassium tests on the same day to determine if potassium levels have normalized. The initial test is billed without modifier 91, and one (1) unit of service. The three (3) additional tests are billed using modifier 91 and three (3) units of service.

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.

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, and Medically Unlikely Edit files. These files contain specific code pairs for Column I/II, Mutually Exclusive, and Medically Unlikely 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 and Provider Field Consultants will not provide specific coding guidance with regard to NCCI editing. The team members will refer inquiries 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 IHCP Web site at www.indianamedicaid.com. The provider must clearly note "Administrative Review" on the form and attach all pertinent documentation, and add "Attention: Health Care Administrative Review Specialist."

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The formal administrative review request must be filed within seven days of notification of claim payment or denial from HP. This policy is consistent with the current administrative review policy which can be found in the *IHCP Provider Manual, Chapter 10, Section 6*.

Providers can submit requests for administrative reviews to:

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

Providers with concerns about specific code pair editing concerns may be submitted in writing to:

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

Important: The Correct Coding Solutions address listed above is not to be used for Administrative Reviews or Appeals. This is only to be used in circumstances where the provider has questions or concerns about the validity of either a procedure-to-procedure edit or a medically unlikely edit value. This is not for situations where IHCP policy may conflict with NCCI editing.

QUESTIONS?

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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