Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 209
April 2011

TO: All Providers Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: **Medicaid National Correct Coding Initiative**

Background

Section 6507 of the federal Affordable Care Act (Public Laws 111-148 and 111-152), as implemented by the Centers for Medicare & Medicaid Services (CMS), requires state Medicaid agencies to incorporate compatible methodologies of the National Correct Coding Initiative (NCCI). NCCI was implemented by CMS to promote national correct coding methodologies and to control improper coding to minimize inappropriate payment. This requirement is effective for MassHealth claims with dates of service on or after October 1, 2010, that are processed on or after April 1, 2011.

Procedure-to Procedure Code Pair Editing

MassHealth implemented Medicare NCCI procedure-to-procedure code pair editing during its conversion to NewMMIS. Medicaid NCCI adds some additional code pairs for NCCI editing. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are billed by the same provider for the same member on the same date of service.

Full lists of Medicaid NCCI edit code pairs can be found on the CMS Web site at

http://www.cms.gov/MedicaidNCCICoding/06_NCCIandMUEEdits.asp#TopOfPage.

The above link is included in this bulletin for the sole purpose of providing access to the NCCI edit code pairs lists (e.g., see below for MassHealth modifier policy). CMS may update these lists. Providers should periodically review these lists for changes that CMS may make to them. MassHealth may need to periodically reprocess claims to edit against updated lists. Note that MassHealth applies NCCI procedure-to-procedure editing to all providers who bill using HCPCS/CPT codes.

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Medically Unlikely Edits (MUE) Limits

Medicaid NCCI includes Medically Unlikely Edits (MUEs). MUEs are units-of-service edits that define for certain HCPCS/CPT codes the number of units of service beyond which the reported number of units of service is unlikely to be correct (for example, claims for excision of more than one gallbladder or more than one pancreas). Full lists of Medicaid NCCI MUEs can be found on the CMS Web site at

http://www.cms.gov/MedicaidNCCICoding/06_NCCIandMUEEdits.asp#TopOfPage.

The above link is included in this bulletin for the sole purpose of providing access to the NCCI MUE lists. CMS may update these lists. Providers should periodically review these lists for changes that CMS may make to them. MassHealth may need to periodically reprocess claims to edit against updated lists. Note that MassHealth applies the MUE limits to all providers who bill using HCPCS/CPT codes.

Claims Processing

Claims for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, and are billed using HCPCS/CPT codes will be edited for NCCI procedure-to-procedure edits. Any claims using HCPCS/CPT codes that include code pairs on the NCCI edit list will result in payment denials unless the applicable MassHealth payment method does not use these HCPCS/CPT codes to determine the current payment amount.

Claims for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, and are billed using HCPCS/CPT codes will be edited against the MUE limits. Any claims using HCPCS/CPT codes billed with units of service greater than the MUE limit will result in payment denials unless the applicable MassHealth payment method does not use these HCPCS/CPT codes to determine the current payment amount.

MassHealth will apply these methodologies to all claims containing the applicable HCPCS and CPT codes.

Due to the timing of system updates, MassHealth may need to later reprocess and adjust claims processed during April 2011, to ensure proper NCCI editing.

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Claims Processing *(cont.)*

Note that MUE limits and procedure-to-procedure code edits supersede any approved prior authorizations (PA) in the system. Claims over the MUE limit or that include code pairs on the NCCI edit lists will be denied even if they have an approved PA that would otherwise allow coverage of the service. If a claim with such an approved PA is denied solely due to the NCCI denial reasons specified below, providers should request an agency review of the denial using the process described below.

Agency Review and Appeals

A provider whose claim for payment is denied due **solely** to a procedure-to-procedure code edit or an MUE edit may request MassHealth review of the denial. Claims denied for these reasons will have the following denial reasons/codes.

5927 – NCCI - Another Service Prev Paid – Same Claim
5928 – NCCI - Another Service Prev Paid – Other Claim
5929 – NCCI - Conflict With Other Service Prev Paid
5930 – MUE Units Exceeded

Requests for MassHealth agency review of claims denials that include additional denial reasons or are denied for any other reasons must follow the current resubmittal processes specified in 130 CMR 450.323. The review process described herein is only for denials due **solely** to a procedure-to-procedure code edit or an MUE edit with a denial reason listed above.

Pursuant to such a request, the provider must demonstrate that
(1) the service for which payment was denied was a medically necessary MassHealth-covered service for the member;
(2) the provider's claim was properly completed and submitted in accordance with all MassHealth requirements;
(3) the provider satisfied all other prerequisites for payment;
(4) payment was denied solely due to a procedure-to-procedure or MUE edit; and
(5) the service is otherwise payable under MassHealth's coverage, billing, and payment rules.

A provider must file its request for MassHealth agency review, accompanied by all supporting documentation, within 30 days of the date on the remittance advice on which the claim denial appears, to the following address.

MassHealth
ATTN: Prior Authorizations/NCCI
100 Hancock Street, 6th floor
Quincy, MA 02171

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Agency Review and Appeals *(cont.)*

The provider's request for MassHealth agency review must include the following information:

- a legible paper copy of the denied claim;
- a copy of the section of the remittance advice that includes as the sole reason for denial one or more of the denial reasons listed on page 3 of this bulletin;
- medical documentation sufficient to support a determination by MassHealth that the service for which payment was denied is medically necessary in accordance with 130 CMR 450.204, or the prior authorization number assigned by MassHealth for the service, if applicable;
- the provider name, provider identification number/service location (PID/SL), and contact information; and
- any other information that MassHealth requires after submission of the initial request.

MassHealth or its designee will review the documentation submitted by the provider and either pay or deny the claim. If the claim is denied, the denial notice will include the right to file a claim for an adjudicatory hearing and instructions to file such a claim.

A provider must request MassHealth review and meet all requirements specified herein in order to preserve its right to file a claim for an adjudicatory hearing and its right to judicial review.

Modifier Not Covered Denials

CMS's current list of NCCI-related modifiers is: 25, 27, 58, 59, 78, 79, 91, LT, RT, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, RC, TA, T1, T2, T3, T4, T5, T6, T7, T8, and T9.

Use of Modifiers

Modifiers associated with NCCI may not be covered by MassHealth for certain codes and certain provider types. Providers must consult Subchapter 6 of their applicable MassHealth provider manual or other MassHealth guidance such as transmittal letters and payment and coverage guidelines tools specific to their programs, to determine if any modifiers are covered and, if so, with which codes they can be used.

If the provider submits a claim with a modifier that is not covered, the claim will be denied with reason "Modifier not covered." Providers may not request agency review using the process described above if payment was denied for this reason. To receive one of the four denial reasons listed on page 3 of this bulletin and the associated right to request agency review as described above, providers must bill the claim without the modifier.

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Duplicate claim denials

Billing units on separate claim lines to remain under an MUE limit may result in the following denial reasons.

5010 – Exact Duplicate - Outpatient Claim
5032 – Exact Duplicate - Outpatient Procedures
5044 – Exact Duplicate - Physician Claim

Providers may not request agency review using the process described above if payment was denied for these reasons. To receive the "MUE units exceeded" denial reason and the associated right to request agency review as described above, providers must bill the total units on one claim line.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.