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

MassHealth
Chronic Disease and Rehabilitation
Outpatient Hospital Bulletin 5
May 2014

TO: Chronic Disease and Rehabilitation Outpatient Hospitals Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: **NCCI Procedure-to-Procedure Code Pair Denial for Therapy Services**

Background

MassHealth implemented Medicaid National Correct Coding Initiative (NCCI) as required by the Affordable Care Act (ACA) in 2011. *See* All Provider Bulletin 209. This bulletin includes information for chronic disease and rehabilitation outpatient hospital providers who provide more than one type of therapy service to a member on the same day, including information on procedure-to-procedure code pair editing and when providers may use a modifier to bypass the procedure code pair edit. A procedure code pair edit occurs when a procedure-to-procedure code pair is billed by the same provider for a member on the same date of service.

For dates of service beginning July 1, 2012, MassHealth expanded its list of allowable modifiers to include modifiers that may be used to bypass code pair edits when both procedures are medically necessary and separately identifiable. All Provider Bulletin 227 includes a list of allowable modifiers and appropriate circumstances in which they should be used.

Therapy Service Visits

MassHealth regulations allow a limited number of medically necessary physical, occupational, and speech/language therapy visits within a 12-month period before requiring prior authorization. (See 130 CMR 410.408). The number of medically necessary visits payable within a 12-month period without a prior authorization is

- 35 speech/language therapy visits,
- 20 physical therapy visits and
- 20 occupational therapy visits.

Requests for prior authorization beyond these limits must include a completed Request and Justification for Therapy Services Form THP-2 ("Form") to document justification of continued therapy service. When billing MassHealth for therapy services, providers must indicate the procedure code and the therapy discipline modifier for the service (GN=speech; GP=physical and GO=occupational), in addition to an approved prior authorization number if there is one.

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Modifier Use

CMS has identified a set of modifiers to facilitate claims-processing for service codes that are not usually separately payable when billed in combination on the same date of service by the same provider, including CMS-designated NCCI code pairs. For dates of service starting July 1, 2012, MassHealth began allowing certain modifiers to more accurately define service encounters and avoid claim denials due to certain system edits, including certain NCCI code pair edits that don't otherwise allow payment for two medically necessary, separately identifiable services/procedures. MassHealth allows the use of a modifier to result in payment of both procedure codes in an NCCI code pair only if CMS has given the code pair a Modifier Indicator ("Indicator") of "1." If the Indicator is "0," payment is allowed for only one of the procedure codes on the same date of service. Please refer to the CPT Manual on the use of modifiers when billing. It is important that providers use modifiers only when appropriate. Providers continue to be responsible for ensuring that all services furnished are medically necessary and are billed appropriately. (*See* All Provider Bulletin 227.)

Billing Multiple Therapy Codes on Same Day

Services before a prior approval is required: If a member receives medically necessary services in multiple therapy disciplines on the same date of service and the procedure codes conflict but have a Modifier Indicator of "1," you can append the appropriate modifier to one of the procedure codes in order to get paid for both codes. You are responsible for ensuring that only medically necessary services are provided and billed for.

Services that require prior approval: Providers are required to request prior approval for therapy services beyond the MassHealth limits as stated above. When a claim is submitted with a prior-approval number, MMIS will match data on the prior-approval number with the following data on the claim in order to process the claim correctly: the service code, unit number, therapy discipline modifier, and any additional modifier needed. If the provider indicates, for example, modifier 59 on a claim which has a prior-approval number and the prior-approval number was assigned without the indication of modifier 59, the claim will be denied. Information relevant to the procedure code (i.e. modifiers and units) must match both the prior-approval and claim when billing for services with procedure-to-procedure code edits. All claims must include the above information for all units approved under the prior-approval number.

Requesting Prior Approval for Procedure Code Pair Conflict

Effective June 1, 2014, if a member is receiving multiple therapy services on the same day by the same provider but under different therapy disciplines, the provider must determine if the services constitute an NCCI procedure code pair conflict and whether use of a modifier is appropriate. If the NCCI procedure code pair allows a modifier, and using the modifier is appropriate in the circumstances, the provider must include the allowable modifier on the prior-approval request form in addition to the all other required information.

Denied Claims

MassHealth has identified denied claims, Error Code 5929-NCCI Conflict with Other Service Previously Paid, for therapy services when multiple therapy procedure codes for the same member are billed on the same date of service by the same provider.

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Denied Claims *(cont.)*

Providers that have claims that have denied with Error Code 5929 for the reason described above should request that the Prior Approval Unit add the appropriate modifier to the prior approval procedure code that was denied. All requests must be submitted in writing and can be emailed to the Prior Approval Unit at priorauthorization@umassmed.edu. Requests must include:

- the prior-approval number;
- the procedure code with therapy discipline modifier; and
- the appropriate modifier to add to procedure code.

The Prior Approval Unit will change the prior approval number by adding the requested modifier to the unused balance of units on the prior approval. After the Prior Approval Unit has changed the prior approval number, the Prior Approval Unit will notify the provider.

Providers should rebill denied claims within 90 days from the date of notification from the Prior Approval Unit, according to the guidelines below.

Deciding If a Claim Should Be Resubmitted, Replaced, or Subject to Special Consideration

To determine the method of resubmission, the provider must use the following guidelines.

A. If the claim is in a denied status and the date of service is within one year, the claim must go through the resubmission process.
B. If the claim is in a paid status with some detail lines paid and some denied and the date of service is within one year, the claim must be replaced.
C. If the claim is over the one-year time limit, once you have received a modified prior authorization, it must be submitted on a compact disc (CD) in the correct 837 format. The CD must contain only the affected claims that were denied with edit 5929 and are also over the one-year time limit, along with a copy of this bulletin. All of the claims that denied with edit 5929 should be submitted on one CD. To avoid denials for untimely filing, please send the 837 file to the following address:

    Claims Operations
    Attn: Karen Pinkham
    100 Hancock Street, 6th floor
    Quincy, MA 02171

Providers have the option to submit special consideration claims via direct data entry (DDE) and indicate delay reason code 11; the provider must attach a copy of this bulletin with the DDE submission.

Questions

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