FACT SHEET

Updates on the Medicaid National Correct Coding Initiative (NCCI) Methodologies

This Fact Sheet provides updates to information provided in State Medicaid Director Letter (SMDL) #10-017, issued on September 1, 2010, in support of implementation of the National Correct Coding Initiative (NCCI) in the Medicaid program. State use of the NCCI methodologies is a requirement under section 6507, Title VI, Subtitle F of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act.

This Fact Sheet updates States and other interested parties on the following four topics in support of implementation of the Medicaid NCCI methodologies:

- change in the location of the Medicaid NCCI edit files for downloading by State Medicaid agencies;

- changes in Medically Unlikely Edits (MUEs) for bilateral surgical procedures;

- the claim adjudication algorithms States are required to use in paying Medicaid claims; and

- reports on changes in the Medicaid NCCI edit files.

Change in the Location of Medicaid NCCI Edit Files for Downloading by States

The Centers for Medicare & Medicaid Services (CMS) posts the updated Medicaid NCCI edit files for each calendar quarter on the Medicaid Integrity Institute (MII) website for downloading by State Medicaid agencies. CMS has relocated the MII website to the Regional Information Sharing Systems Secure Intranet (RISSNET) funded by the U.S. Department of Justice.

Thus, the quarterly updated Medicaid NCCI edit files are now located on the MII website on the RISSNET (www.riss.net). There is a link to RISSNET in the Related Resources box on the NCCI website located at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-National-Correct-Coding-Initiative.html. The procedure to access the files is to first log onto the RISSNET Portal. From the RISSNET Portal home page, click on “Quick Links”. Under “Quick Links”, click on the “Medicaid Integrity Institute” link. On the home page of the MII, click on the “Folders” link, which displays the current list of folders supporting the MII. The Medicaid NCCI edit files are listed under the folder entitled “Medicaid NCCI Methodologies”.

If a State has not received access to the RISSNET, or cannot download the Medicaid NCCI edit files from the MII website on the RISSNET, please contact us immediately.

This change in the location of the Medicaid NCCI edit files does not impact the schedule and timing of posting the updated quarterly Medicaid NCCI edit files. The new quarterly updated files will continue to be uploaded to the RISS website on or about the 15th day prior to the beginning of the calendar quarter. On December 15, 2011, CMS posted to the RISSNET the Medicaid NCCI files effective for the calendar quarter January – March 2012.

We wish to note that no changes have been made to the Medicaid NCCI edit file formats because of the relocation of the MII website to RISSNET. However, to accommodate the current restrictions on file size for downloading files from RISSNET, the Medicaid NCCI edit files are posted as zip files. The public Medicaid NCCI edit files are posted at the beginning of each calendar quarter on the Medicaid.gov website in the same file formats as they were posted on the CMS.gov website.

Changes in Medically Unlikely Edits (MUEs) for Bilateral Procedures

CPT modifier 50 is used to indicate a bilateral procedure, which is a procedure that can be performed on an organ that a body has two of (e.g., eye, ear, arm, leg, kidney, ovary, etc.). Medicare's standard billing instructions specify that, when a bilateral surgical procedure is performed during the same provider visit, modifier 50 should be appended to the HCPCS / CPT code and one unit of service (UOS) should be reported on the claim line. Billing one UOS on a claim line in conjunction with modifier 50 for a bilateral procedure will result in the claim line passing a MUE with a value of one. However, prior to January 1, 2012, the codes for many surgical procedures that can be performed bilaterally had a Medicare MUE value of two.

Consequently, to conform to Medicare's published coding instructions, Medicare reduced the values of MUEs for over 1,200 surgical procedure codes that can be performed bilaterally and that previously had an MUE value of two. Medicare reduced the values of these MUEs from two to one. The reduced values for these MUEs became effective January 1, 2012.

Section 6507 of the Affordable Care Act mandates that State Medicaid programs use compatible Medicare NCCI methodologies in processing their Medicaid claims effective October 1, 2010. Therefore, the changes in the values of those Medicare MUEs were also made to the corresponding Medicaid MUEs. On January 1, 2012, the MUE values for over 1,200 surgical procedure codes were reduced from two to one in the Medicare and Medicaid MUE files for January – March 2012.

One of the objectives of the CMS NCCI program is to ensure the correct coding of medical services billed on Medicare and Medicaid claims. The specific surgical procedure codes that are affected are included in the Medicaid MUE Change Reports that are posted to the MII / RISSNET and Medicaid.gov websites, along with the quarterly Medicaid NCCI edit files, for access by the States.

These changes affect State Medicaid programs that have instructed providers to bill bilateral surgical procedures with modifier 50 and two UOS on a single claim line. In those cases, the MUEs with the new values will result in denial of payment of all UOS billed on the claim line for these procedures. In those situations, a short-term solution would be to instruct providers to

bill the procedures on two separate claim lines, using modifier RT with one UOS on one claim line and modifier LT with one UOS on the other claim line. (For procedures involving the eyelids, fingers, or toes, the more specific modifiers E1 – E4, F1 – F9, FA, T1 – T9, and TA should be used, instead of RT and LT.)

A State Medicaid agency may also request through its CMS Regional Office CMS approval to deactivate these revised MUEs. To do so, the agency must include in its request:

- a list of the edits the agency requests to deactivate;

- specification of whether the requested deactivation is for practitioner (PRA), outpatient hospital (OPH), or durable medical equipment (DME) edits;

- the rationale for the requested deactivation; and

- a copy of, or link to, the State law, regulation, administrative rule, or payment policy which conflicts with the revised MUEs.

Over the long term, States should align their claims processing systems and provider billing instructions with standard coding practice requiring all bilateral surgical procedures to be reported with modifier 50 and one UOS on a single claim line.

At the current time, the MUEs for diagnostic radiological procedures reportable with modifier 50, when performed bilaterally, have not been modified.

Claim Adjudication Algorithms Required for Paying Medicaid Claims

CMS released SMDL #10-017 on September 1, 2010, and indicated that States must incorporate all five Medicare NCCI methodologies into their systems for processing Medicaid claims effective October 1, 2010. CMS indicated that, consistent with section 6507 of the Affordable Care Act, the five Medicare NCCI methodologies were compatible with Medicaid.

Each of the five NCCI methodologies consists of four components. States must implement all five of the Medicaid NCCI methodologies in their entirety, including all four components of each methodology, in processing Medicaid claims.

One of the components consists of definitions of the types of claims subject to the edits. A second component is a set of rules for addressing provider / supplier appeals of denied services based on the edits. On April 1, 2011, CMS issued State Medicaid Director Letter #11-003 on the "National Correct Coding Initiative: Appeals" to inform States of CMS policy on State implementation of this component.

A third component consists of the Procedure-to-Procedure (PTP) edits and the Medically Unlikely Edits (MUEs). The fourth component consists of the claim adjudication algorithms for these two types of NCCI edits.

- The claim adjudication algorithm for the PTP edits includes the following requirements:

  - If the Correct Coding Modifier Indicator (CCMI) for the edit is "0", the column one HCPCS / CPT code is eligible for payment and the column two HCPCS / CPT code is denied.

  - If the CCMI for the edit is "1", the column one code is eligible for payment and the column two code is denied, unless the provider has appended one of the NCCI PTP-associated modifiers to either code of the edit pair. If an NCCI PTP-associated modifier is appended to either code, the PTP edit is bypassed. The NCCI PTP-associated modifiers are the following: 25, 27, 58, 59, 78, 79, 91, E1 – E4, FA, F1 – F9, TA, T1 – T9, LT, RT, LC, LD, and RC. The State's claims processing system **must** recognize <u>all</u> of these modifiers and allow the PTP edit to be bypassed, if <u>any</u> of these modifiers is used on either code of the edit pair. Failure to do this will result in incorrect denials of payment that will be falsely attributed to NCCI.

- The claim adjudication algorithm for the MUEs includes the following requirements:

  - When the number of UOS billed on a claim line exceeds the MUE value for the HCPCS / CPT code on the claim line, a State must deny payment of all UOS on the claim line. A State cannot pay the UOS up to the MUE value for that code and deny payment of UOS above the MUE value.

    This is stated in Enclosure B (page 13) of SMDL #10-017:

    > If more units of service are reported for the HCPCS / CPT code on a claim line than the MUE value for the code on that claim line, the entire claim line is denied. The claims processing contractor during the automated processing of the claim should NOT pay any units of service on the claim line, if the MUE is triggered for a claim line. The provider / supplier will have to resubmit the claim, if the Fiscal Agent (or the State-contracted entity that performs claims processing activities on behalf of the State Agency) permits this process, or will have to appeal the claim line denial to receive payment for any units of service denied based on an MUE. For some procedures (e.g., colectomy), the MUE is an absolute limit. However, for other procedures, providers / suppliers may occasionally report units of service in excess of the MUE value by reporting the same code on more than one line of a claim with appropriate coding modifiers.

    Medicare adopted the MUE program to reduce error rates in payments of Part B claims and to promote correct coding. Medicare denies all UOS on a claim line where the UOS exceeds the MUE value, rather than directing its claims processing contractors to pay UOS up to the MUE value and deny UOS above this value. Many services are coded incorrectly because some providers select the wrong code, utilize the wrong UOS, report services that are not medically reasonable and necessary, and / or are over-utilizing services. If UOS on a claim line are paid up to the MUE value and payment is denied for UOS above the MUE value on a claim line, there is little incentive for providers to reconsider the

appropriateness of the coding submitted for their services. Paying UOS up to the MUE value and denying payment of UOS above the MUE value is unlikely to alter incorrect coding by providers.

If a State pays UOS on a Medicaid claim line up to the MUE value for that code and denies payment of UOS above the MUE value, the State may be over-paying that claim and is likely paying for some Medicaid claims that should not be paid. Such a practice is not in compliance with section 6507 of the Affordable Care Act and SMDL #10-017.

- When a date span is used on a claim line, the submitted UOS must be divided by the number of days in the date span and the result must be rounded to the nearest whole number. That value is then compared to the MUE value to determine whether the edit applies. If a State implements this algorithm, allowing providers to report span dates for HCPCS / CPT codes will not cause reported UOS to exceed the MUE value for a claim line. There is no need to deactivate the MUE values solely because a State allows use of span dates on claim lines.

States should refer to the *Medicaid NCCI Edit Design Manual* that is posted on the Medicaid.gov and RISS websites for additional requirements concerning the claim adjudication algorithms for PTP edits and MUEs.

Compliance with section 6507 of the Affordable Care Act and SMDL #10-017 requires State use of these claim adjudication algorithms in paying Medicaid claims. Therefore, States must use the Medicaid NCCI methodologies in paying Medicaid claims, including using the claim adjudication algorithms for PTP edits and MUEs.

Reports on Changes in the Medicaid NCCI Edit Files

As of January 2012, CMS has begun posting reports on changes in new quarterly Medicaid NCCI edit files on the MII / RISSNET and Medicaid.gov websites in both Excel and Tab-Delimited ASCII text formats.

There are two Excel documents identifying changes to the PRA and OPH PTP edits from the prior quarter to the current quarter. Each PTP Excel document has three worksheets: Additions, Deletions, and Changes to Correct Coding Modifier Indicator. For each Excel document, there are three related ASCII text documents, corresponding to the three worksheets in the Excel document. Therefore, there are a total of eight documents addressing changes to PTP edits.

There are three Excel documents identifying changes to the PRA, OPH, and DME MUEs. Each MUE Excel document has three worksheets: Additions, Deletions, and Revisions. For each Excel document, there are three related text documents, corresponding to the three worksheets. Therefore, there are a total of 12 documents addressing changes to MUEs.

A more detailed description of the change reports will be incorporated in an upcoming revision of the *Medicaid NCCI Edit Design Manual*, which is posted on the MII / RISSNET and Medicaid.gov websites.

State Medicaid agencies should utilize the change reports to identify areas of potential impact to their operations, e.g., estimating the volume of potential denials and provider inquiries and assessing the need for provider education on selected subjects. If a State determines that a particular Medicaid NCCI edit is in conflict with its laws, regulations, administrative rules, or payment policies, it may request through its CMS Regional Office CMS approval to deactivate the edit. To do so, the agency must include in its request:

- a list of the edits the agency requests to deactivate;

- specification of whether the requested deactivation is for PRA, OPH, or DME edits;

- the rationale for the requested deactivation; and

- a copy of, or link to, the State law, regulation, administrative rule, or payment policy which conflicts with the MUE.

A State Medicaid agency should **NOT** use the change reports to make individual changes to its NCCI edits. The complete Medicaid NCCI edit files for PTP edits and MUEs that are now posted on the MII / RISSNET web site on a quarterly basis should completely replace the prior quarter's Medicaid NCCI edits in the State's system for processing its Medicaid claims. Deactivations of Medicaid NCCI edits which have been approved by CMS are implemented on the complete set of NCCI edits on a quarterly basis.

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