pennsylvania
DEPARTMENT OF PUBLIC WELFARE

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 10, 2011	December 1, 2011	99-11-10

SUBJECT
Announcing the Federally Mandated Implementation of the National Correct Coding Initiative (NCCI) in the Pennsylvania Department of Public Welfare's Medical Assistance Program

BY
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IMPORTANT REMINDER: If you submit HIPAA compliant electronic healthcare claim transactions to the department, you need to be prepared for the ANSI X12 v5010 and NCPDP vD.0 upgrades in order to prevent the rejection of your claims. The CMS mandated compliance date for all covered entities to use the new standards is January 1, 2012. For additional information, visit the DPW website at:
http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/softwareandservicevendors/hipaa5010d.0upgradeinformation/index.htm

PURPOSE:

The purpose of this bulletin is to inform providers that the Department of Public Welfare (Department) will implement National Correct Coding Initiative (NCCI) program edits on December 1, 2011, as mandated under the Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148).

SCOPE:

This bulletin applies to providers enrolled in the Medical Assistance (MA) Program who submit professional and outpatient claims as indicated in Attachment A, for services rendered to MA recipients in the Fee-for-Service (FFS) delivery system, including ACCESS Plus. This bulletin does not apply to providers who render services to MA recipients in either the HealthChoices or voluntary managed care delivery system.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Office of Medical Assistance Programs Web site at
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/index.htm

BACKGROUND:

The Centers for Medicare and Medicaid Services (CMS) developed the NCCI coding program for the Medicare Program. Under this program, Medicare carriers implemented NCCI edits to apply Incidental and Mutually Exclusive coding policies and editing to claims filed with dates of service on or after January 1, 1996. The goal of the initiative was to promote national correct coding methodologies and to control improper coding which leads to inappropriate payment of Medicare Part B (practitioner) fee-for-service claims. CMS developed its policies based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of coding practices. On January 1, 2007, the NCCI program was expanded to incorporate Medically Unlikely Edits (MUEs).

NCCI edits are applied to services performed by the same provider for the same recipient on the same date of service. There are two types of NCCI edits:

(1) NCCI procedure-to-procedure edits - define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together. These code pairs are subject to Incidental and Mutually Exclusive coding policies and editing.

(2) MUE units-of-service edits - define for each HCPCS/CPT code the number of units beyond which the reported number of units is unlikely to be correct.

CMS identified five methodologies within the two types of NCCI edits; two NCCI procedure-to-procedure methodologies and three MUE methodologies. The methodologies are:

1. NCCI procedure-to-procedure edits for practitioner and ambulatory surgical center (ASC) services;
2. NCCI procedure-to-procedure edits for outpatient hospital services;
3. MUE units-of-service edits for practitioner and ASC services;
4. MUE units-of-service edits outpatient hospital services; and
5. MUE units-of-service for supplier claims for durable medical equipment.

Section 6507 of the Patient Protection and Affordable Care Act (ACA) requires all State Medicaid programs to incorporate NCCI methodologies which include coding policies and edits, in their claims processing systems effective for claims filed on and after October 1, 2010. On September 1, 2010, CMS issued guidelines to States for implementing the NCCI methodologies and because of the need for States to update their claims processing systems, CMS allowed additional time for States to prepare for implementation. Claims that have been submitted and processed between the suggested CMS implementation date of October 1, 2010 and prior to the States' implementation are not required to be reprocessed.

DISCUSSION:

NCCI Implementation

The Department will implement NCCI edits in a phased approach. The first phase is addressed in this bulletin and only incorporates the NCCI procedure-to-procedure code edits that are subject to the Incidental and Mutually Exclusive coding policies and editing CMS supplied to Medicaid. The second phase will incorporate MUEs and will be addressed in a separate bulletin at a later time.

The NCCI code pair edits have been reviewed by the Department's clinicians and policy analysts to ensure that the edits being implemented are consistent with current PA Medicaid laws, regulations, administrative rules, and/or payment policies and the MA fee schedule. A complete listing of the NCCI coding policies and edits can be located on the CMS website.

Please refer to Attachment A for a department listing of the categories of claims included and excluded from the editing process.

NCCI Quarterly Update Process

CMS will issue updates to the Medicaid NCCI edits on a quarterly basis. Any new NCCI code pair edits will be reviewed by the department's clinicians and policy analysts prior to the CMS effective date to ensure that they are consistent with current PA Medicaid laws, regulations, administrative rules, and/or payment policies, and the MA fee schedule. Providers may access the updated files on the CMS website at:

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

NCCI Procedure-to-Procedure Edits

Incidental Edits – The edits are returned when a commonly performed procedure is performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure.

Example: A recipient presents to the short procedure unit or physician's office for removal of a lesion from the trunk. The physician submits a claim for MA payment with procedure codes 17313 and 88302.

•17313 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.

•88302 – Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic ganglion, Testis, castration, Vaginal mucosa, incidental, Vas deferens, sterilization.

The surgical pathology (88302) is incidental to the removal of the lesion by Moh's surgery (17313) because the surgical procedure includes the examination of the specimens (in this case, the skin/lesion removed from the trunk) by the surgeon. In this scenario, NCCI incidental editing will result in the denial of the claim for procedure code 88302.

Mutually Exclusive Edits – These edits are returned when a provider submits a claim with two procedures that differ in technique or approach but lead to the same clinical outcome and represent an overlapping of services.

Example: A recipient presents to the operating room for percutaneous skeletal fixation of a supracondylar humeral fracture. During the percutaneous procedure the radiological findings indicate poor alignment of the fracture and the surgeon proceeds to treat the fracture by open treatment to assure good bone alignment.

• 24538 – Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension.

• 24545 - Open treatment of humeral supracondylar or transcondylar fracture, include internal fixation, when performed; without intercondylar extension.

Procedure code 24538 is mutually exclusive to 24545 because the result of the surgical procedure was repair of the same supracondylar fracture. Despite the fact that the treatment was started via percutaneous route, the surgeon had to open the site to adequately repair the fracture and get good alignment. When similar or identical procedures are performed, but are qualified by an increased level of complexity, only the definitive, or most comprehensive, service performed should be reported. In this scenario, NCCI mutually exclusive editing will result in the denial of the claim for procedure code 24538.

For each of the edits identified, PROMISe™ will return an Error Status Code (ESC) message. The ESC and description will be displayed to the provider on a Remittance Advice (RA). Four new NCCI ESCs will be introduced with the implementation of the first phase of NCCI procedure-to-procedure edits. There will be two ESCs each for Incidental and Mutually Exclusive editing. A list of all PROMISe™ ESCs and their descriptions, as well as those related to NCCI procedure-to-procedure edits are available on the Department's website at:

http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_001987.pdf

PROCEDURE:

On December 1, 2011, the Department will implement NCCI procedure-to-procedure edits for professional and outpatient claims as identified in Attachment A, for services provided in the FFS delivery system, including ACCESS Plus. All new claims received on and after December 1, 2011, will be subject to NCCI editing, including claims submitted for dates of service on and after October 1, 2010. Claims processed prior to the implementation date will not be reprocessed.

Providers should use the MA Program Fee Schedule, as well as the appropriate coding manuals and clinical guidelines, to ensure that claims are submitted with the correct procedure codes and modifiers for the service provided and to reduce unnecessary claim denials.

Providers will be referred to the CMS NCCI contractor if the provider requests an explanation or policy clarification for an NCCI program edit, or requests reconsideration of an NCCI edit.

Please note: Current MA payment procedures will remain the same. The requirements in the billing guidelines and the claims processing time frames will not be affected by the implementation of NCCI editing. In addition, claims will continue to be subject to PROMISe™ and ClaimCheck® edits and audits. See Medical Assistance Bulletin 99-08-17 titled "Implementation of ClaimCheck®". The NCCI edits will be placed ahead of ClaimCheck® edits and audits; and therefore, if there is a duplication of edits it is the NCCI edit that will set.

Attachment: Attachment A, NCCI Claims Criteria

References and Resources:

CMS Overview Medicaid NCCI Coding website:

http://www.cms.gov/MedicaidNCCICoding