NATIONAL CORRECT CODING INITIATIVE (NCCI)

Lauryn Davis & Christopher Lawhorn

WHO'S WHO IN MEDICAID

NC Division of Medical Assistance

Departments of Social Services

WHO'S WHO IN MEDICAID

Division of Medical Assistance

- Recipient and Provider Services
- Clinical Policy and Programs
- Managed Care
- Quality, Evaluation, and Health Outcomes
- Finance Management
- Budget Management
- Program Integrity
- IT and HIPAA

OVERVIEW

The Patient Protection and Affordable Care Act [(H.R. 3590) Section 6507 (Mandatory State Use of National Correct Coding Initiative)] requires State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems.

GENERAL BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims.

GENERAL BACKGROUND

The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national Medicare policies, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

NORTH CAROLINA MEDICAID IMPLEMENTATION

To comply with the NCCI mandate DMA will implement the two mandatory components on March 31, 2011.

Updates Available:

http://www.ncdhhs.gov/dma/provider/ncci.htm

NCCI EDITS CONSIST OF TWO TYPES OF EDITS:

1)Procedure-to-Procedure Edits (CCI Edits)

2)Medically Unlikely Edits (MUE)

NCCI PROCEDURE-TO-PROCEDURE EDITS:

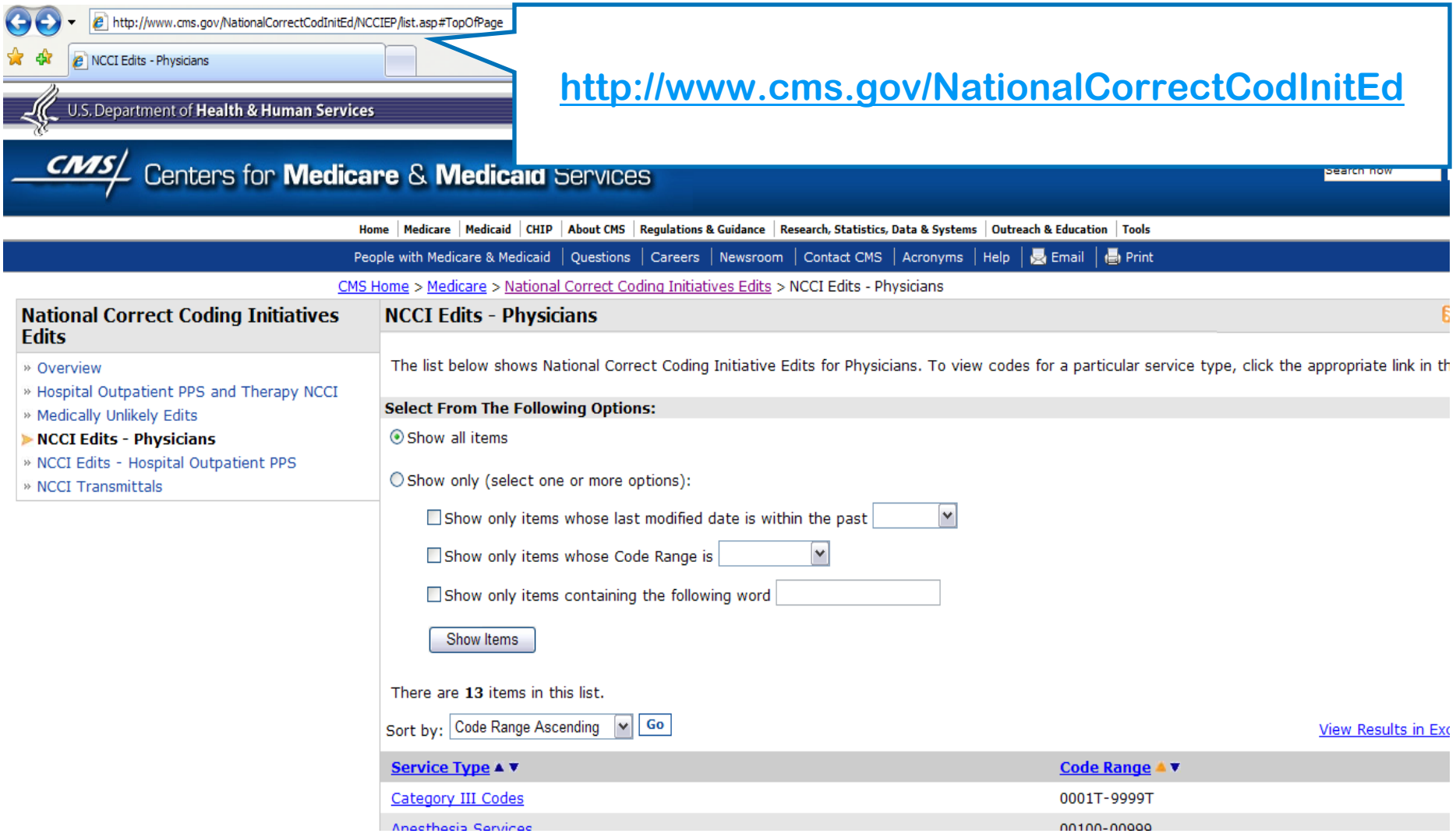
NCCI procedure-to-procedure (CCI) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons

PROVIDERS AFFECTED
NCCI PROCEDURE -TO- PROCEDURE EDITS

- Practitioner Services
- Ambulatory Surgical Centers
- Outpatient Hospital Services
  - Drugs
  - Radiology
  - Laboratory Services

PROVIDERS AFFECTED
NCCI PROCEDURE-TO-PROCEDURE EDITS

http://www.cms.gov/NationalCorrectCodInitEd



PROVIDER AFFECTED NCCI PROCEDURE-TO-PROCEDURE EDITS

Practitioners

- Certified Registered Nurse Anesthetists
- Children's Developmental Service Agencies
- Chiropractors
- Community Intervention Services
- Critical Access Behavioral Health Agencies
- Dialysis Centers
- Federally Qualified Health Centers
- Independent Laboratories
- Independent Outpatient Behavioral Health Therapists
- Independent Outpatient Specialized Therapists
- Local Education Agencies
- Nurse Midwives
- Nurse Practitioners
- Optometrists
- Pharmacies (non-Point-of-Sale)

***Please note this list is not All inclusive*

PROVIDERS AFFECTED NCCI PROCEDURE-TO-PROCEDURE EDITS

Practitioners

- Physician Services, such as
  - Anesthesiology
  - Cardiology
  - Dermatology
  - Full-time Emergency Room Physicians
  - General/Family Practices
  - OB/GYN Practices
  - Osteopathy
  - Orthopedics/Hand Surgery
  - Pathology
  - Radiology
  - Podiatry
- Portable X-ray Services
- Prosthetics and Orthotics Suppliers
- Psychiatrists
- Rural Health Clinics
- School-Based Health Centers

***Please note this list is not All inclusive*

*If necessary please note that you can utilize NCCI-associated Modifiers to bypass NCCI edits, if in accordance with coding guidelines and if applicable to the services rendered.

PROVIDERS AFFECTED
NCCI PROCEDURE-TO-PROCEDURE EDITS

Outpatient Hospital Services

Drugs

Radiology

Laboratory Services

***If necessary please note that you can utilize NCCI associated modifiers to bypass NCCI edits, if in accordance with coding guidelines and if applicable to the services rendered.**

PROVIDERS AFFECTED
NCCI PROCEDURE-TO-PROCEDURE EDITS

Outpatient Hospital Services

Bill Type: 12X without condition code 41

14X without condition code 41

13X 75X and 74X

***If necessary please note that you can utilize NCCI-associated modifiers to bypass NCCI edits, if applicable to services rendered.**

PROVIDERS AFFECTED
NCCI PROCEDURE-TO-PROCEDURE EDITS

Outpatient Hospital Services

Revenue Codes:

RC250	RC301	RC312	RC409	RC634
RC251	RC302	RC314	RC610	RC635
RC252	RC304	RC319	RC611	RC636
RC254	RC305	RC350	RC612	
RC255	RC306	RC351	RC614	
RC258	RC307	RC352	RC615	
RC257	RC309	RC359	RC616	
RC259	RC310	RC402	RC618	
RC300	RC311	RC404	RC619	

DMA SAMPLE CCI EDITS

Accepted Procedure Code	Accepted Procedure Code Description	Rejected Procedure Code	Rejected Procedure Code Description
11300	Shaving of epidermal or dermal lesions	69990	Use of Operating Microscope
21406	Excisions of benign mandible cyst	43752	Nasogastric tube placement
40652	Repair lip, up to half of the vertical height	46654	Repair lip, over half vertical height

***Note: This list is as of Jan 2011 and is subject to change.

NCCI MEDICALLY UNLIKELY EDITS:

Medically Unlikely Edits (MUE) these are units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct.

PROVIDERS AFFECTED
NCCI MEDICALLY UNLIKELY EDITS

- **Practitioner Services**
- **Ambulatory Surgery Centers**
- **Outpatient Hospital Services**
- **Durable Medical Equipment Suppliers**

PROVIDER AFFECTED NCCI MEDICALLY UNLIKELY EDITS

Practitioners

- Certified Registered Nurse Anesthetists
- Children's Developmental Service Agencies
- Chiropractors
- Community Intervention Services
- Critical Access Behavioral Health Agencies
- Dialysis Centers
- Federally Qualified Health Centers
- Independent Laboratories
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- Independent Outpatient Specialized Therapists
- Local Education Agencies
- Nurse Midwives
- Nurse Practitioners
- Optometrists
- Pharmacies (non-Point-of-Sale)

***Please note this list is not All inclusive*

PROVIDERS AFFECTED
NCCI MEDICALLY UNLIKELY EDITS

Practitioners

- Physician Services, such as
  - Anesthesiology
  - Cardiology
  - Dermatology
  - Full-time Emergency Room Physicians
  - General/Family Practices
  - OB/GYN Practices
  - Osteopathy
  - Orthopedics/Hand Surgery
  - Pathology
  - Radiology
  - Podiatry
- Portable X-ray Services
- Prosthetics and Orthotics Suppliers
- Psychiatrists
- Rural Health Clinics
- School-Based Health Centers

***Please note this list is not All inclusive*

*If necessary please note that you can utilize NCCI-associated Modifiers to bypass NCCI edits, if in accordance with coding guidelines and if applicable to the services rendered.

PROVIDERS AFFECTED
NCCI MEDICALLY UNLIKELY EDITS

Outpatient Hospital Services

Drugs

Radiology

Laboratory Services

***If necessary please note that you can utilize NCCI associated modifiers to bypass NCCI edits, if in accordance with coding guidelines and if applicable to the services rendered.**

PROVIDERS AFFECTED
NCCI MEDICALLY UNLIKELY EDITS

Outpatient Hospital Services

Bill Type: 12X without condition code 41

14X without condition code 41

13X 75X and 74X

***If you are not currently allowed to submit with modifiers; please note that you can utilize NCCI-associated modifiers to bypass NCCI edits.**

PROVIDERS AFFECTED
NCCI MEDICALLY UNLIKELY EDITS

Outpatient Hospital Services

Revenue Codes:

RC250	RC301	RC312	RC409	RC634
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RC258	RC307	RC352	RC615	
RC257	RC309	RC359	RC616	
RC259	RC310	RC402	RC618	
RC300	RC311	RC404	RC619	

DMA SAMPLE MUE EDITS

Procedure Code	Procedure Code Description
99284	ER Visit/units 1
E0443	Portable oxygen contents gaseous 1 month=1unit/units 4
32440	Removal of lung/units 1
50610	Ureterolithotomy, upper 1/3 of ureter/units 2
35206	Repair blood vessel, hand/units 3

***Note: This list is as of Jan 2011 and is subject to change.

WHEN WILL THE CHANGES TAKE PLACE?

When the edits are implemented in

March 2011, CCI and MUE edits will impact claims with dates

of service on and after

March 31,2011.

WHAT TO LOOK FOR….?

The CCI and MUE edit explanation of benefits (EOBs) will appear on the provider's Remittance and Status (RA) Report.

WHAT TO LOOK FOR…?

- **EOB 9988 – "Payment of procedure code is denied based on CCI editing"**

- **EOB 9953 – "Payment of procedure code is denied based on MUE editing"**

WHAT TO LOOK FOR…?

- **EOB 9955 - "Claim recouped based on CCI editing"**
- **EOB 9956 – "Detail recouped based on CCI editing"**

WHAT TO LOOK FOR….?

North Carolina Medicaid – Remittance and Status Advice

NPI

Provider Number:

Date: 02/15/2011 Page: 3

Name / Recipient ID	Service Dates From	Service Dates To	Days/ Units	Procedure/Accommodation/ DrugCode and Description	Total Billed	Non Allow	Total Allowed	Payable Cutback	Payable Charge	Other DedChg	Paid Amount	Exp Codes

CLAIMS PAYMENT SUMMARY EFT NUMBER

	CLAIMS PAID	PAID CLAIMS AMOUNT	A WITHHELD AMOUNT(*)	B NET PAY AMOUNT (A-B)	C CREDIT AMOUNT	D NET 1099 AMOUNT (C-D)	E IRS WITHHELD AMOUNT	F POS & EDI	G	H OTHER W/H	I ADJUSTED NET PAY (C-E-G-H)
CURRENT	1	138.09	.00	138.09	.00	138.09	.00	.00		.00	138.09
YTD TOTAL	909	41863.94	.00	41863.94	.00	41863.94	.00	.08		.00	41863.86

1099 INFORMATION 2011 - THIS INFORMATION IS BEING FURNISHED TO THE INTERNAL REVENUE SERVICE

PROVIDER TAX ID:

PAYER ID: HP ENTERPRISE SERVICES , LLC, PO BOX 30968 RALEIGH, NC 27622 #

PLEASE VERIFY THE FOLLOWING IDENTIFICATION NUMBERS THAT HAVE BEEN ASSIGNED TO YOU. IF ANY OF THE NUMBERS ARE INCORRECT, PLEASE SEND CORRECTIONS TO:

HP
PO BOX 300009
RALEIGH, NORTH CAROLINA 27622
ATTENTION: PROVIDER ENROLLMENT

CLIA -
DEA -

FOR BILLING QUESTIONS/INQUIRIES CALL HP PROVIDER SERVICES 1-800-688-6696 OR AUTOMATED VOICE RESPONSE (AVR)SYSTEM 1-800-723-4337

AN EXPLANATION AND JUSTIFICATION FOR ALL NCCI EDITS ON A CLAIM AND LINE LEVEL BASIS CAN BE ACCESSED THROUGH THE NORTH CAROLINA ELECTRONIC CLAIMS SUBMISSION/RECIPIENT ELIGIBILITY VERIFICATION WEB TOOL (NCECSWEB TOOL) AT HTTPS://WEBCLAIMS.NCMEDICAID.COM/NCECS.
A DENIAL DUE TO AN NCCI EDIT MAY BE APPEALED BY THE PROVIDER. THE PROVIDER MAY NOT BILL A MEDICAID RECIPIENT FOR AN NCCI DENIAL.

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED THROUGHOUT THE REPORT
NCXIX 73 CLAIM PAID COPAYMENT DEDUCTED
NCXIX 98 FEE ADJUSTED TO MAXIMUM PAYABLE
NCXIX 9988 PAYMENT OF PROCEDURE CODE IS DENIED BASED ON NCCI EDIT

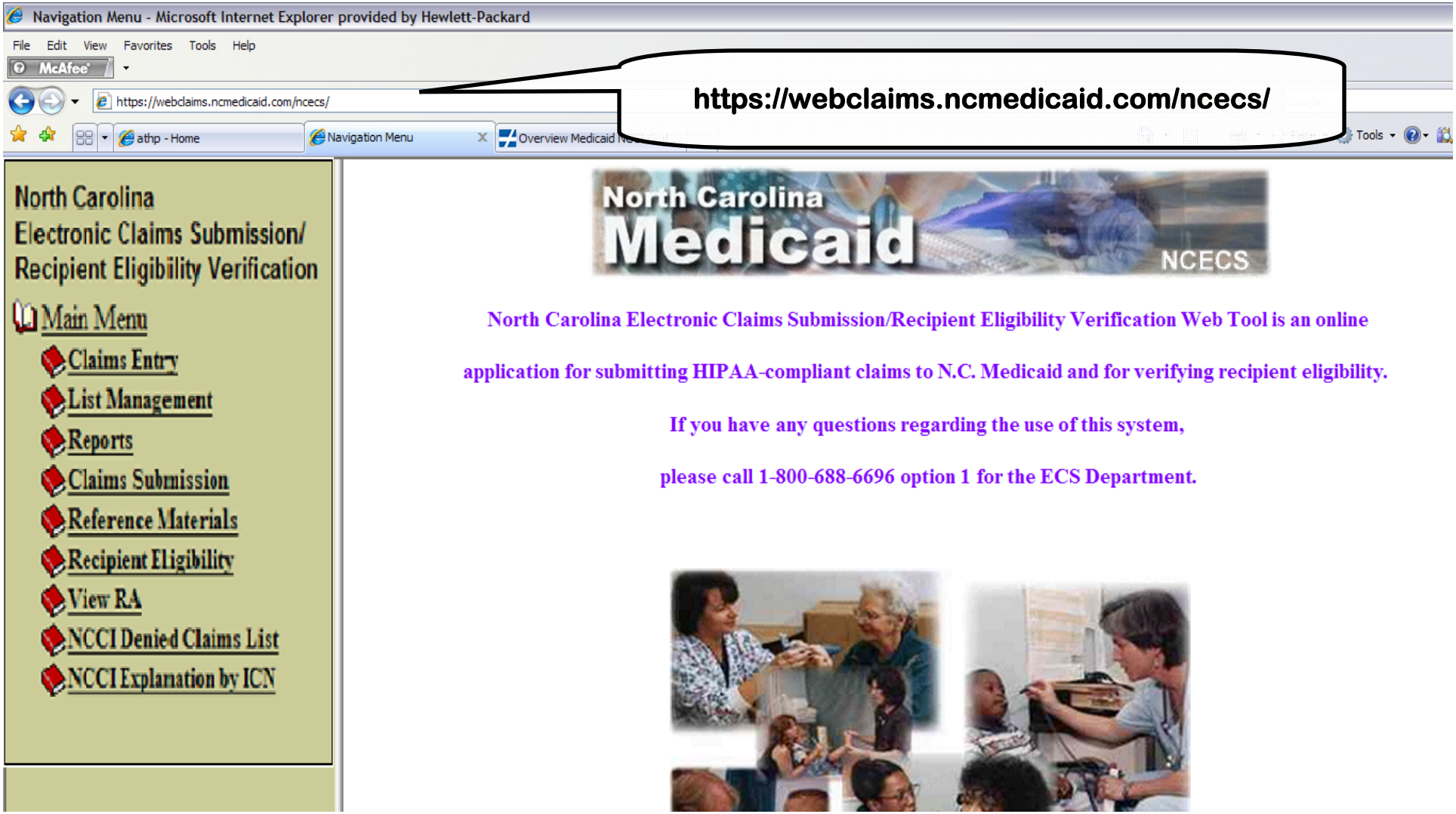
REMITTANCE AND STATUS NCCI ACCESS

Providers who currently have an NCECSWeb Tool logon ID and password and can view their RA in PDF format will be automatically enrolled for access.

If you do not currently have an NCECSWeb Tool logon ID and password, you must complete a *Remittance and Status Reports in PDF Format/NCCI Information Request Form*.

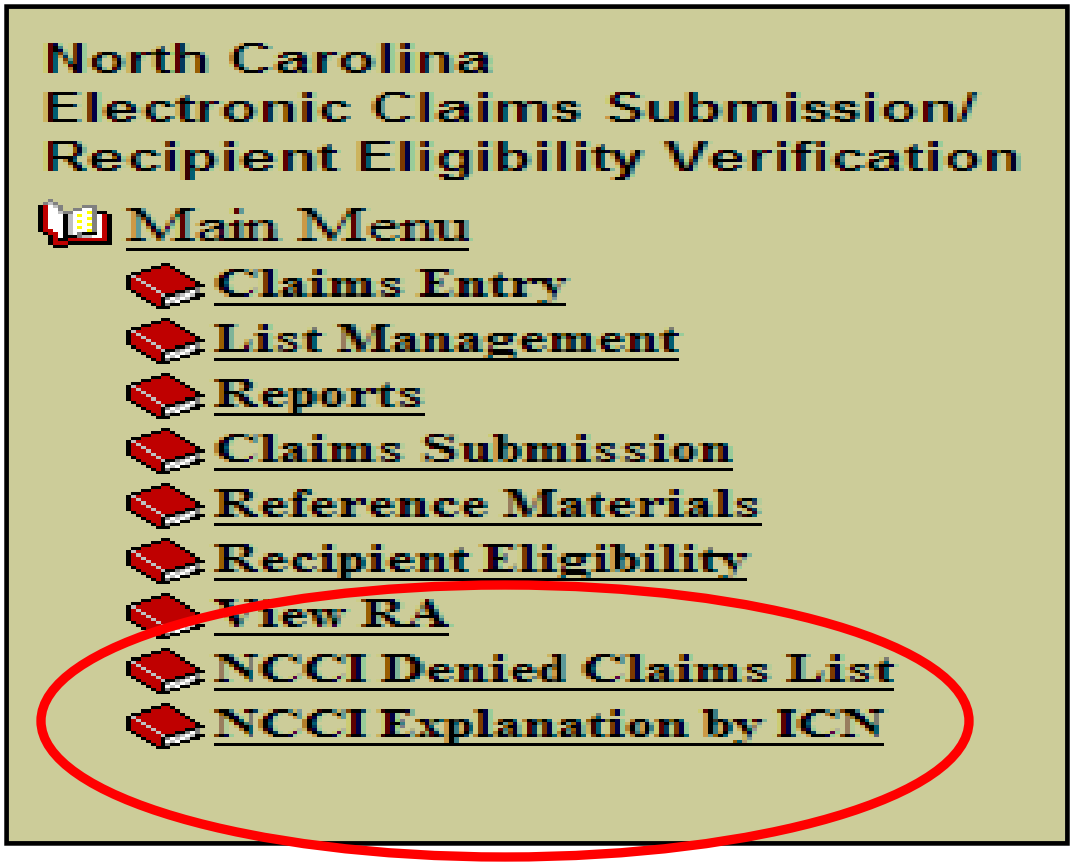
http://www.ncdhhs.gov/dma/provider/forms.htm

REMITTANCE AND STATUS NCCI ACCESS



REMITTANCE AND STATUS NCCI ACCESS

New Books Added to NCECSWeb Tool:



ACCESSING NCCI EXPLANATIONS

NCCI Denied Claims List

Paid Date: MM/DD/YYYY				
ICN	FDOS	TDOS	PCode	Bill Amt
252011001222222	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001333333	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001444444	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001444444	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001555555	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001666666	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011001777777	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
---	---	---	---	---
252011001888888	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
Paid Date: MM/DD/YYYY				
252011999123123	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011999321321	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011999456789	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
252011999456789	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
---	---	---	---	---
252011998878787	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99

Prev Next

ACCESSING NCCI EXPLANATIONS

NCCI Explanation by ICN

ICN	FDOS	TDOS	PCode	Bill Amt
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
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Back to ICN Entry Screen

ACCESSING NCCI EXPLANATIONS

Audit 1

CCI|MCD

Payment of 36600 is denied because it is not payable with 43753 based on an ncci edit.

Details

Claim Number	Line	HCPCS	Modifier	Units	Creation Source	Role in Audit	Action
	002	36600		1	Submitted on Claim	Action Required	Not Reimbursable
	003	43753		1	Submitted on Claim	Considered in Determination	None

Sources

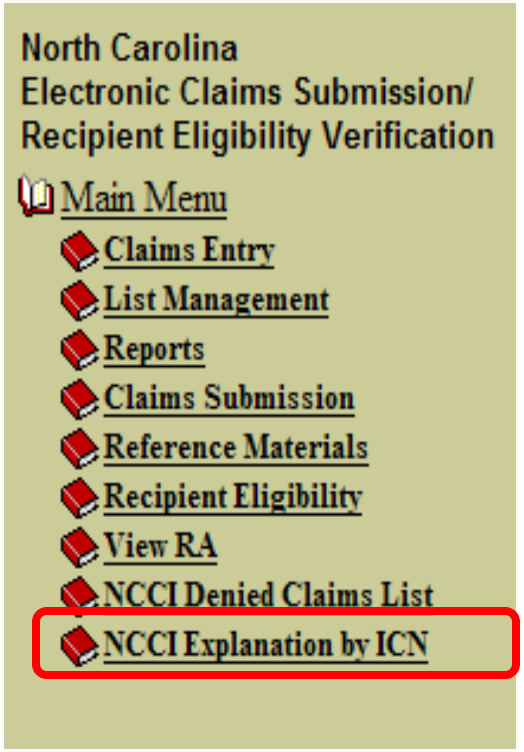
Center for Medicare Services|CMS Guidelines

Effective from 10/01/2010 through current

The Patient Protection and Affordable Care Act requires Medicaid to adopt NCCI methodologies. NCCI procedure-to-procedure edits are pairs of HCPCS/CPT codes consisting of a column one code and a column two code. The edit defines two codes that should not be reported together for a variety of reasons. If both codes are reported, the column one code is eligible for payment and the column two code is denied.

ACCESSING NCCI EXPLANATIONS

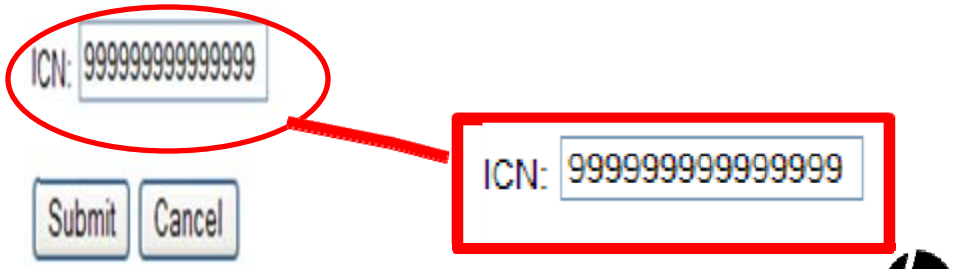
NCCI Explanation by ICN



Enter the ICN for which you want a detailed explanation

The ICN entered must belong to the provider associated with the logged on user ID.

If more than one claim was denied for NCCI edits on entered ICN, a list of information for those will be displayed and you will be able to select the specific detail from that list



ACCESSING NCCI EXPLANATIONS

NCCI Explanation by ICN

ICN	FDOS	TDOS	PCode	Bill Amt
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
999999999999999	MM/DD/YYYY	MM/DD/YYYY	XXXXX	999999999.99
---	---	---	---	---

Prev Next

Back to ICN Entry Screen

ACCESSING NCCI EXPLANATIONS

NCCI Explanation by ICN

Audit 3

MUE | MCD

Units of 99218 exceed medically unlikely edit.

Details

Claim Number	Line	HCPCS	Modifier	Units	Creation Source	Role in Audit	Action
	16	99218		29	Submitted on Claim	Action Required	Not Reimbursable

Sources

Center for Medicare Services | CMS Guidelines

Effective from 10/01/2010 through current

Per The Act, State Medicaid programs are required to implement NCCI methodologies into claims processing systems. MUE units of service edits are coding edits, not utilization or payment edits. These edits are based on anatomic considerations.

REMINDER

- Providers must report services correctly
- Providers should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services
- Providers should not fragment a procedure into component parts
- Providers should not unbundle a bilateral procedure code into two unilateral procedure codes
- Providers must avoid down coding
- Providers must avoid up coding
- Providers must report units of service correctly

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

HOW TO KNOW IF A CLAIM CAN BE MODIFIED

http://www.cms.gov/NationalCorrectCodInitEd

Downloads

How to Use The National Correct Coding Initiative (NCCI) Tools [PDF, 2.94MB]

CR5824 [PDF 154KB]

MM5824 [PDF 72KB]

NCCI Policy Manual for Medicare Services, Version 16.3 - Effective October 1, 2010 [PDF/ZIP 551KB]

Medicare Claims Processing Manual (Sec. 20.9) [PDF, 1.2MB]

Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service [PDF, 20KB]

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

Service Type	Code Range
Category III Codes	0001T-9999T
Anesthesia Services	00100-00999
Anesthesia Services	01000-09999
Surgery: Integumentary System	10000-19999
Surgery: Musculoskeletal System	20000-29999
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems	30000-39999
Surgery: Digestive System	40000-49999
Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems	50000-59999
Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems	60000-69999
Radiology Services	70000-79999

Service Type

Code Range

1 2 Next › Last »

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

Column 1	Column 2	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
90378	G0345	20050101	20050101	9
90378	G0347	20050101	20050101	9
90378	36000	20021001	*	1
90378	36410	20021001	*	1
90378	90780	20010701	20041231	1
90378	90783	20010701	20041231	0
90378	90784	20010701	20041231	0
90378	90788	20010701	20041231	0
90460	G0008	20110101	*	1
90460	G0009	20110101	*	1
90460	G0010	20110101	*	1

HOW TO CORRECT CLAIMS

Modifier Indicator	Definition
"0" Not Allowed	There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
"1" Allowed	The modifiers associated with NCCI are allowed with this code pair when appropriate.

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can NEVER overturn the denial with one exception. An administrative law judge can determine that the denied column two code should be paid.

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1" the provider can make modifications to the previously submitted claim and should do so by updating the claim with the necessary information and resubmit as a new day claim.

HOW TO CORRECT CLAIMS

Procedure-to-Procedure Process

If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment. NCCI-associated modifiers and their appropriate use can be found on the CMS website:

http://www.cms.gov/MedicaidNCCICoding/

HOW TO CORRECT CLAIMS

- **Overview**
- ~~COTS Software~~
- NCCI Appeals
- Correspondence Language Manual & CLEID
- Medicare Modifier 59 Article
- NCCI and MUE Edits

The Patient Protection and Affordable Care Act ((H.R. 3590) Section 6507 (Mandatory State Use of National Co
State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems by October 1, 2
National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control impro
payments in Medicare Part B claims. The purpose of the NCCI edits is to prevent improper payments when inco

NCCI edits consist of two types of edits:

1) NCCI procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPC
codes that should not be reported together for a variety of reasons; and

2) Medically Unlikely Edits (MUE), units-of-service edits, that define for each HCPCS / CPT code the number of u
number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder or mor

Section 6507 of the Affordable Care Act (ACA) requires that, by September 1, 2010, CMS must notify States of
"compatible" with claims filed with Medicaid that would promote correct coding and control improper coding lead
under Medicaid. The CMS will be issuing a State Medicaid Director Letter for this purpose. The CMS must also r
that should be incorporated into claims filed with Medicaid for which no national correct coding methodology has
must incorporate these methodologies into Medicaid claims filed on or after October 1, 2010. By March 1, 2011,
with an analysis supporting these methodologies.

Downloads

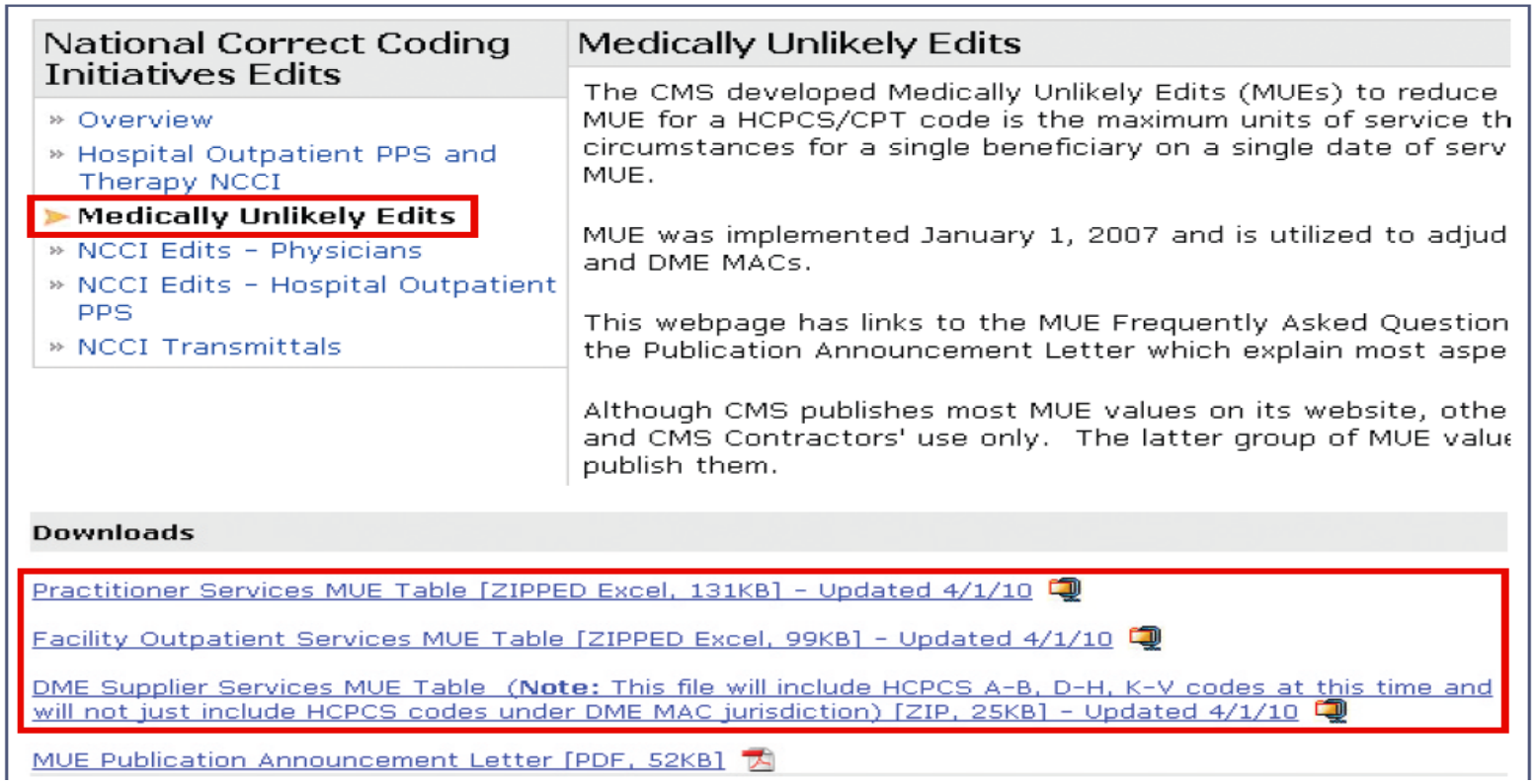
NCCI File Names and Formats, Algorithms for Processing Claims, and Characteristics of Edits [62KB PDF]

Medicaid NCCI Coding Policy Manual [PDF 635KB]

HOW TO CORRECT CLAIMS

MUE Process

How to Determine the allowed Units of Services



National Correct Coding Initiatives Edits

- Overview
- Hospital Outpatient PPS and Therapy NCCI
- **Medically Unlikely Edits**
- NCCI Edits – Physicians
- NCCI Edits – Hospital Outpatient PPS
- NCCI Transmittals

Medically Unlikely Edits

The CMS developed Medically Unlikely Edits (MUEs) to reduce
MUE for a HCPCS/CPT code is the maximum units of service th
circumstances for a single beneficiary on a single date of serv
MUE.

MUE was implemented January 1, 2007 and is utilized to adjud
and DME MACs.

This webpage has links to the MUE Frequently Asked Question
the Publication Announcement Letter which explain most aspe

Although CMS publishes most MUE values on its website, othe
and CMS Contractors' use only. The latter group of MUE value
publish them.

Downloads

Practitioner Services MUE Table [ZIPPED Excel, 131KB] – Updated 4/1/10

Facility Outpatient Services MUE Table [ZIPPED Excel, 99KB] – Updated 4/1/10

DME Supplier Services MUE Table (**Note:** This file will include HCPCS A-B, D-H, K-V codes at this time and will not just include HCPCS codes under DME MAC jurisdiction) [ZIP, 25KB] – Updated 4/1/10

MUE Publication Announcement Letter [PDF, 52KB]

HOW TO CORRECT CLAIMS

MUE Process

How to Determine the allowed Units of Services

HCPCS/CPT Code	MUE
Current Procedural Terminology © 2010 American Medical Association. All Rights Reserved. Current Procedural Terminology (CPT) is copyright 2010 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.	
86335	2
86336	1
86337	1
86340	1
86341	1
86343	1
86344	1
86355	1
86357	1

APPEALS PROCESS

Providers may submit a letter requesting reconsideration of a CCI/MUE denial to DMA at the address listed below. The request must include documentation supporting medical necessity.

Division of Medical Assistance
Appeals Unit
Clinical Policy and Programs
2501 Mail Service Center
Raleigh, NC 27699-2501

RESOURCES & ADDITIONAL INFO

Additional information is available on the CMS website:

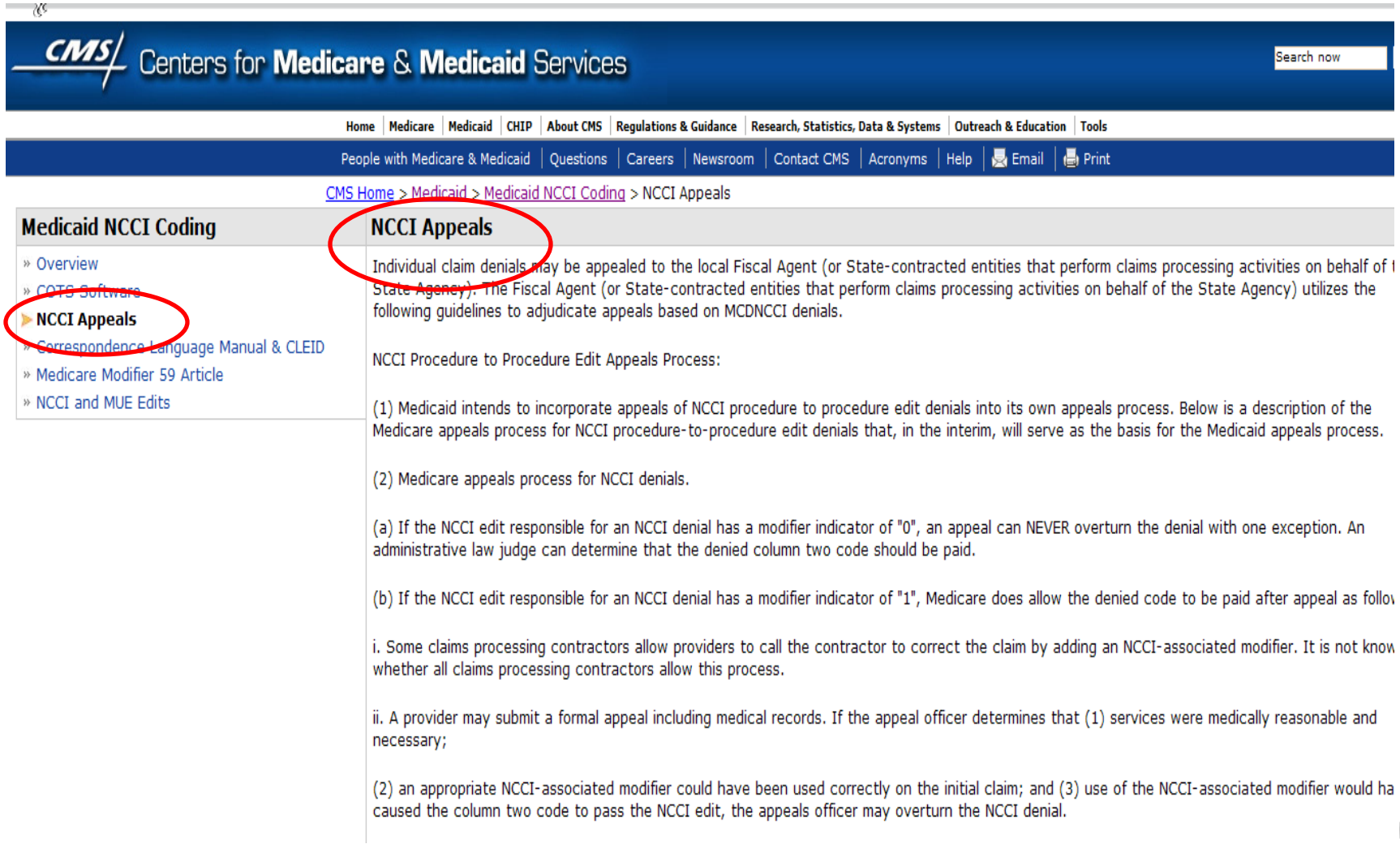
http://www.cms.gov/MedicaidNCCICoding/

This site is complete with the following information:

- **General Overview**
- **Medicaid NCCI Coding Policy Manual**
- **Additional Information on Coding Policies and Edits**
- **Federal Appeals Guidelines and Information**
- **FAQs and a How To Manual**

RESOURCES & ADDITIONAL INFO

RESOURCES & ADDITIONAL INFO



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NCCI Appeals

Individual claim denials may be appealed to the local Fiscal Agent (or State-contracted entities that perform claims processing activities on behalf of t State Agency). The Fiscal Agent (or State-contracted entities that perform claims processing activities on behalf of the State Agency) utilizes the following guidelines to adjudicate appeals based on MCDNCCI denials.

NCCI Procedure to Procedure Edit Appeals Process:

(1) Medicaid intends to incorporate appeals of NCCI procedure to procedure edit denials into its own appeals process. Below is a description of the Medicare appeals process for NCCI procedure-to-procedure edit denials that, in the interim, will serve as the basis for the Medicaid appeals process.

(2) Medicare appeals process for NCCI denials.

(a) If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can NEVER overturn the denial with one exception. An administrative law judge can determine that the denied column two code should be paid.

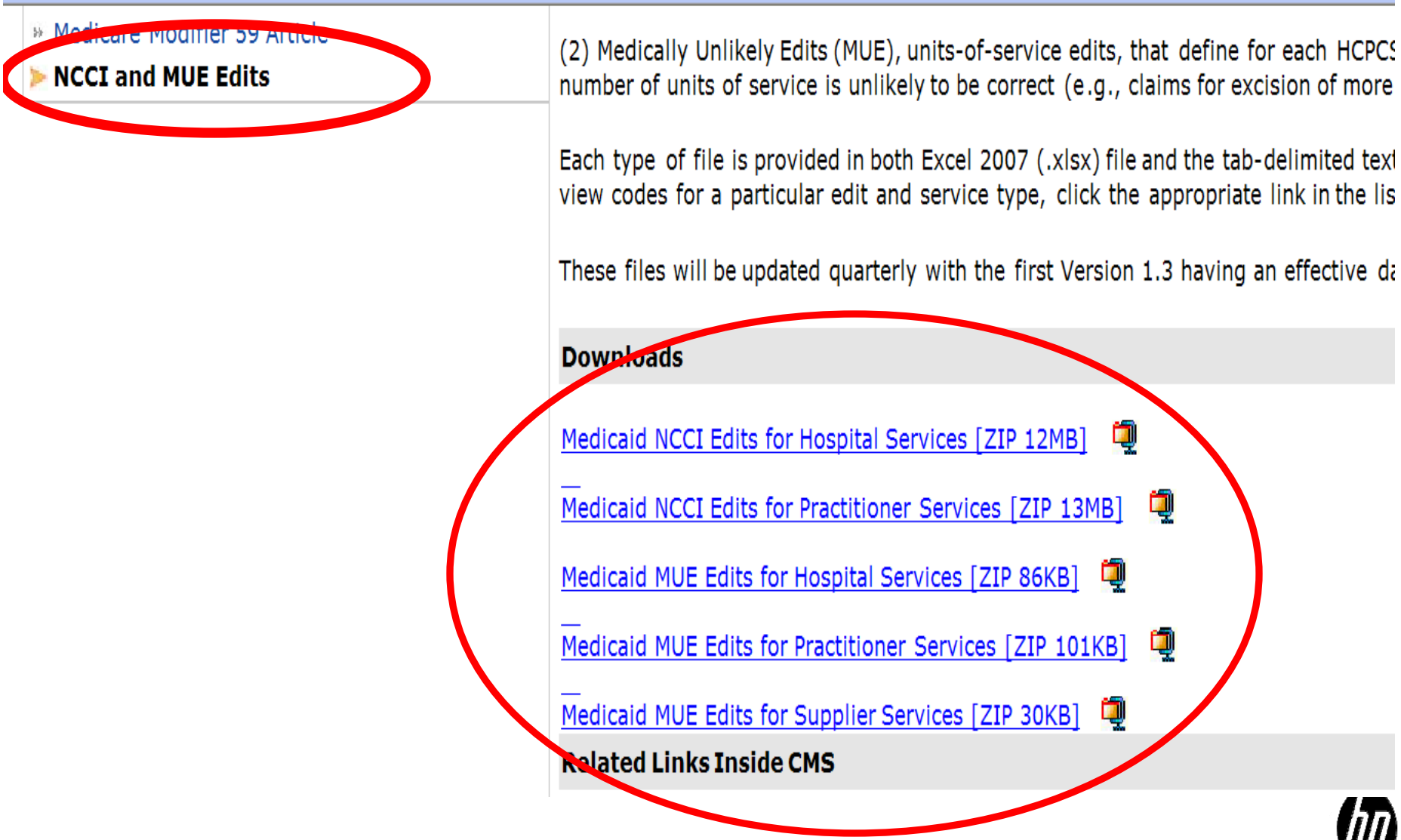
(b) If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1", Medicare does allow the denied code to be paid after appeal as follo

i. Some claims processing contractors allow providers to call the contractor to correct the claim by adding an NCCI-associated modifier. It is not know whether all claims processing contractors allow this process.

ii. A provider may submit a formal appeal including medical records. If the appeal officer determines that (1) services were medically reasonable and necessary;

(2) an appropriate NCCI-associated modifier could have been used correctly on the initial claim; and (3) use of the NCCI-associated modifier would ha caused the column two code to pass the NCCI edit, the appeals officer may overturn the NCCI denial.

RESOURCES & ADDITIONAL INFO



RESOURCES & ADDITIONAL INFO

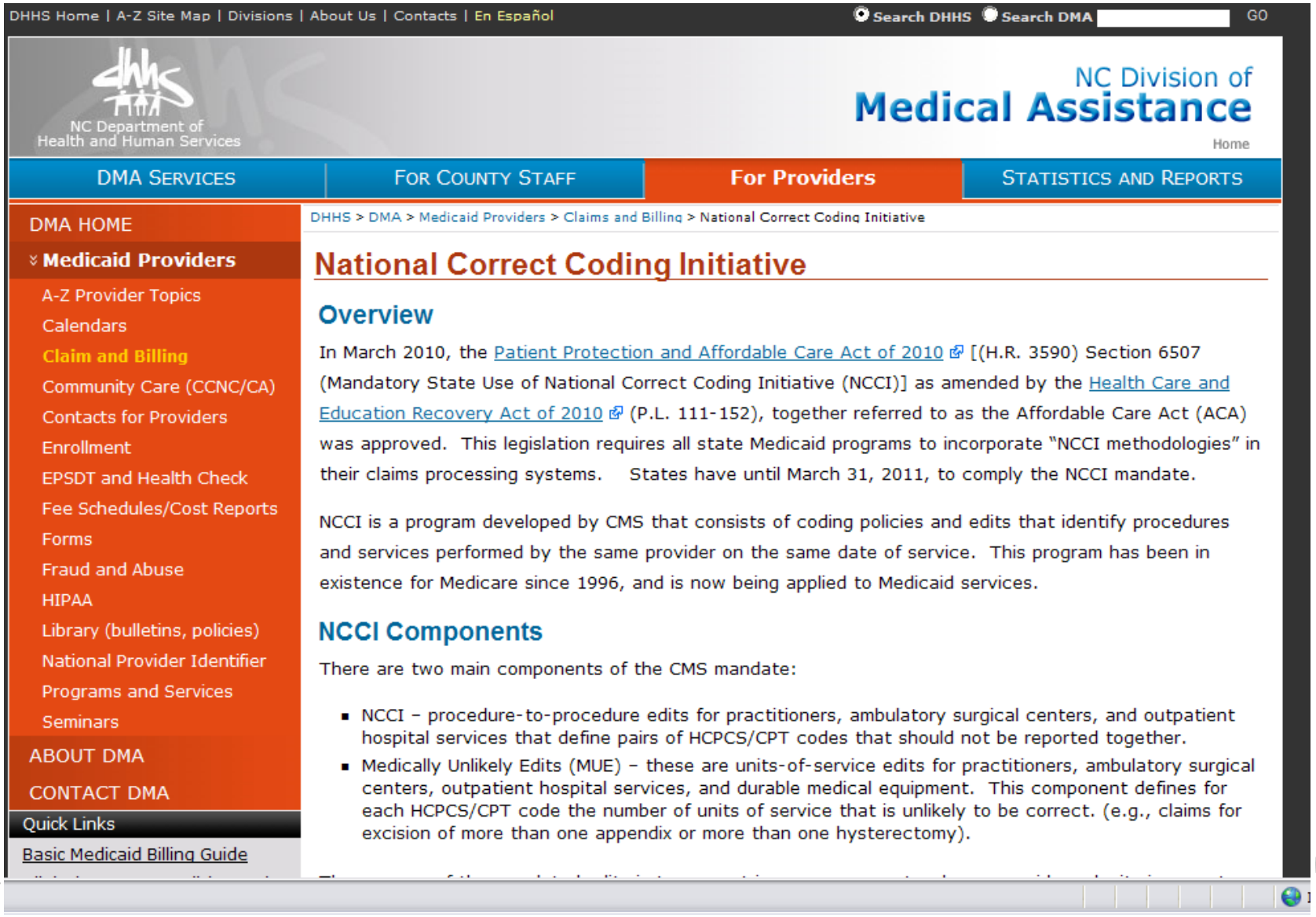
Additional information is available on the DMA website:

http://www.ncdhhs.gov/dma/provider/ncci.htm

This site is complete with the following information:

- **General Overview**
- **North Carolina Implementation Information**
- **Links to NCCI related Bulletins**
- **Links to CMS website**

RESOURCES & ADDITIONAL INFO



RESOURCES & ADDITIONAL INFO

Providers/suppliers who have concerns regarding specific NCCI edits can submit comments in writing to:

National Correct Coding Initiative
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

Fax #: 317-571-1745

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

MEDICAID FOR CHILDREN

Contacts: Frank Skwara, MA, LMFT, BSN, RN
EPSDT Nurse Consultant
Division of Medical Assistance
Telephone #: 919-855-4260
FAX #: 919-715-7679

WHY HEALTH CHECK/ EPSDT ARE IMPORTANT

- Promotes preventative health care by providing for early and regular medical and dental screenings.

- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.

HEALTH CHECK / EPSDT OVERVIEW

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** defined by federal law and includes:

  - Periodic Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care

EPSDT OVERVIEW CON'T.

- Recipients under 21 must be afforded access to the full array of EPSDT services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. Refer to the EPSDT provider web page or the Health Check or Basic Medicaid Billing Guides for a listing of these services.

NOTE: Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

EPSDT CRITERIA

- Must be listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

- Must be medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".

EPSDT CRITERIA CON'T.

"Ameliorate" means to:

- improve or maintain the recipient's health in the best condition possible,
- compensate for a health problem,
- prevent it from worsening, or
- prevent the development of additional health problems.

EPSDT Criteria CON'T.

- Must be determined to be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental, investigational.
- Must be safe.
- Must be effective.

EPSDT FEATURES

- No Waiting List for EPSDT Services
- No Monetary Cap on the Total Cost of EPSDT Services
- No Upper Limit on the Number of Hours under EPSDT
- No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician

EPSDT FEATURES CON'T.

- No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered
- No Co-payment or Other Cost to the Recipient
- Coverage for Services that Are Never Covered for Recipients Over 21 Years of Age
- Coverage for Services Not Listed in the N.C. State Medicaid Plan

IMPORTANT POINTS ABOUT EPSDT

- The full array of EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

Important Points About EPSDT CON'T.

- EPSDT services do not have to be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.

Important Points About EPSDT CON'T.

- EPSDT covers short-term and long-term services as long as the requested services will correct or ameliorate the child's condition. For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not ameliorate the child's condition taken as a whole, but need only be medically necessary to ameliorate one of the child's diagnoses or medical conditions.

EPSDT OPERATIONAL PRINCIPLES

- The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met.

- The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply. This includes the hourly limits on Medicaid Personal Care Services (PCS).

EPSDT OPERATIONAL PRINCIPLES CON'T.

- Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT.

- Out of state services are **NOT** covered if medically necessary similarly efficacious services are available in North Carolina. Out of state services delivered without prior approval will be denied unless there is retroactive Medicaid eligibility.

EPSDT OPERATIONAL PRINCIPLES CON'T.

- Durable medical equipment (DME), assistive technology, orthotics, prosthetics, or other service requested do **NOT** have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.

EPSDT OPERATIONAL PRINCIPLES CON'T.

- The prohibition in CAP/C on skilled nursing for purposes of monitoring does not apply to EPSDT services if skilled monitoring is medically necessary. (Example: PDN)

- Case management is an EPSDT service and must be provided to a child with a Medicaid card if medically necessary to correct or ameliorate regardless of eligibility for a CAP waiver.

EPSDT COVERAGE AND CAP WAIVERS

- CAP Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit unless the waiver service is **ALSO** an EPSDT service.

- Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.

EPSDT COVERAGE AND CAP WAIVERS

CON'T.

- **ANY** child enrolled in a CAP program can receive **BOTH** waiver services and EPSDT services. However, the cost of the recipient's care must not exceed the waiver cost limit.

- If enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD), prior approval to exceed $100,000 per year must be obtained.

EPSDT COVERAGE AND CAP WAIVERS
CON'T.

- A recipient under 21 years of age on a waiting list for CAP services is eligible for necessary EPSDT services without any waiting list being imposed.

- EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services and **may be provided in the school setting, including to CAP-MRDD recipients.**

EPSDT COVERAGE AND MH/DD/SA SERVICES

- Staff employed by local management entities (LMEs) **CANNOT** deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or other appropriate DMA vendors if supported by a licensed clinician.

EPSDT COVERAGE AND MH/DD/SA SERVICES CON'T.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or the DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service. **Only DMA and its contractors can determine if a Medicaid recipient meets criteria for a covered Medicaid service.**

EPSDT COVERAGE AND MH/DD/SA SERVICES CON'T.

- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or to an LME if handling PA in their catchment area.

EPSDT COVERAGE AND MH/DD/SA SERVICES CON'T.

- If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE

- Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.

- EPSDT does **NOT** eliminate the need for prior approval if prior approval is required.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE CON'T.

- Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. When state staff or vendors review a covered state Medicaid plan services request for PA or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver if that service is both a CAP and a waiver service.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE CON'T.

- EPSDT requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE CON'T.

- If the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

- Additionally, all other EPSDT criteria must be met.

REQUESTING PA FOR A COVERED STATE MEDICAID PLAN SERVICE CON'T.

- It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

SERVICES FORMALLY COVERED BY CSHS

- **Cochlear Implant and Accessories**

  Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech or sound processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the implant manufacturer.

SERVICES FORMALLY COVERED BY CSHS CON'T.

- **Pediatric mobility systems**,

  including non-listed components,

  should be sent to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form).

- **Augmentative and Alternate Communication Devices** should be sent to HP Enterprise Services.

SERVICES FORMALLY COVERED BY CSHS CON'T.

- **Oral Nutrition**

  Metabolic formula requests should be sent to DPH.

  All other requests for formula that appear on the DMA fee schedules should be sent to HP Enterprise Services.

  Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

  Assistant Director
  Clinical Policy and Programs

INAPPROPRIATE PA REQUESTS RECEIVED BY VENDORS

- Vendors (CCME, HP Enterprise Services, ACS Pharmacy, MedSolutions, and ValueOptions, PBH, LMEs) may receive service requests for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests will be forwarded to the appropriate vendor for review.

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES

- Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act for recipients under 21 years of age.

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES CON'T.

Over-the-counter (OTC) Medications

If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS) but the drug does not appear on DMA's approved coverage listing of OTC medications, send the request to the Assistant Director, Clinical Policy and Programs, Division of Medical Assistance.

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES CON'T.

- Requests for Medicaid prior approval of DME, orthotics and prosthetics, and home health supplies that do not appear on DMA's lists of covered equipment should be submitted to the Assistant Director, DMA.

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES CON'T.

- Oral Nutrition

Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

Assistant Director
Clinical Policy and Programs

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES CON'T.

Effective with date of request September 1, 2008, Children's Special Health Services no longer authorizes payment for ramps, tie downs, car seats, and vests.

These items are not included in the durable medical equipment covered by Medicaid, nor are they covered under Early Periodic Screening, Diagnostic, and Treatment services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered.

REQUESTING PA FOR NON-COVERED STATE MEDICAID PLAN SERVICES

CON'T.

- Requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to:

Assistant Director for Clinical Policy

and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh, NC 27699-2501

FAX: 919-715-7679

DOCUMENTATION REQUIREMENTS

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes:

- documentation showing that policy criteria are met;
- documentation to support that all EPSDT criteria are met;
- evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

DOCUMENTATION REQUIREMENTS CON'T.

- Requests for non-covered state Medicaid plan services may be submitted on the Non-Covered State Medicaid Plan Services Request form for Children under 21 Years of Age.

- This form is located on the DMA website:

http://www.ncdhhs.gov/dma/provider/forms.htm

DUE PROCESS PROCEDURES

- Requests for prior approval of covered and non-covered state Medicaid plan services are to be decided with reasonable promptness, usually within 15 business days. **No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.**

DUE PROCESS PROCEDURES CON'T.

- If covered or non-covered services are denied, reduced, or terminated, written notice with appeal rights must be provided to the recipient and/or the authorized representative and copied to the provider.

- Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

DUE PROCESS PROCEDURES CON'T.

- The Division's due process procedures fully apply and can be found on the provider page at http://www.ncdhhs.gov/dma/provider/index.htm

DUE PROCESS PROCEDURES CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- "This is the responsibility of the school system."
- "Close supervision, redirection, safety monitoring, assistance with mobility and other ADL's, improving socialization and community involvement, and controlling behavior are not service goals covered under EPSDT."
- "The services would not correct or improve the child's diagnosis."

DUE PROCESS PROCEDURES CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- "EPSDT criteria do not include monitoring a child's actions for an event which may occur."
- "EPSDT services are not long term or ongoing."
- "Teaching coping skills cannot be covered under EPSDT."

EPSDT WEBSITES

- **Basic Medicaid Billing Guide**

  http://www.ncdhhs.gov/dma/basicmed/

- **Health Check Billing Guide**

  http://www.ncdhhs.gov/dma/healthcheck/index.htm

- **EPSDT Provider Page**

  http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm

EPSDT PROVIDER WEBSITE

Q & A