Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2014-98**
www.ctdssmap.com **December 2014**

TO: Chiropractors, Dental Providers, Podiatrists

RE: Expansion of National Correct Coding Initiative to Additional Provider Types

The purpose of this provider bulletin is to notify providers that claims which are reimbursed on the basis of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) are subject to National Correct Coding Initiative (NCCI) edits effective January 1, 2015.

What is National Correct Coding Initiative (NCCI)?

The Centers for Medicare & Medicaid Services (CMS) established the National Correct Coding Initiative program to promote the correct coding of services and to reduce improper coding that could lead to inappropriate payments. The National Correct Coding Initiative was originally implemented by Medicare carriers on January 1, 1996. For the most part, providers have already encountered the application of these methodologies to claims submitted for adjudication and payment by Medicare and private payers. These methodologies have also applied to many providers enrolled in Medicaid since 2010. Effective January 1, 2015 NCCI is being expanded to dental, podiatry, and chiropractic claims.

What are NCCI Edits?

NCCI edits are predetermined edits in the claims system that prevents improper payments when certain codes are submitted together. NCCI edits are applied to services performed by the same provider for the same beneficiary on the same date of service. All services, including services denied based on NCCI edits, may not be billed to Medicaid beneficiaries. CMS updates and posts the NCCI edits quarterly.

Please refer to PB 2010-57, PB 2011-12, PB 2011-41, and PB 2011-53 for further information and explanation of the functionality of the NCCI edits.

To access Provider Bulletins please go to www.ctdssmap.com, and then select "Information," then "Publications," and then go to "Bulletin Search."

Types of NCCI Edits

The National Correct Coding Initiative includes two types of edits, procedure-to-procedure (PTP) edits and medically unlikely edits (MUEs).

1. Procedure-to-procedure (PTP) edits define pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons. The purpose of this edit is to prevent improper payments when incorrect code combinations are reported together.
2. Medically Unlikely Edits (MUEs) define the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service. MUE edits prevent payment for an inappropriate number of UOS in excess of the MUE limit.

Modifiers

In some cases it may be necessary to override the NCCI edit by appending a modifier. Modifiers must be submitted with the appropriate HCPCS or CPT code and documentation of the medical necessity must be in the patient's medical record. Billing with appropriate modifiers allows greater flexibility while still complying with the MUE and PTP edits. Modifiers billed on multiple lines will allow additional units to pay when clinically appropriate. A modifier should not be appended to a HCPCS/CPT code to solely bypass an NCCI edit; providers should continue to report only medically necessary services.

Each procedure code pair is assigned a modifier indicator to identify when it may be appropriate to append a modifier to indicate that separate payment may be warranted. The modifier indicators are as follows:

- **0 (not allowed)**: No modifier associated with or allowed under any circumstance; the code pair will not be paid separately.
- **1 (allowed)**: Modifier is allowed for use to differentiate between the services provided. This indicator allows for separate payment when used correctly.
- **9 (not applicable)**: The edit for the code pair was deleted retro-actively and NCCI edit does not apply to this code pair.

Please see the following tables below for some of the acceptable modifiers. A complete list of modifiers and modifier indicators can be found on the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/

Anatomical Modifiers

Modifier	*Anatomical designation*
T1 to T9 and TA*	Foot and digit
RT*	Right side
LT*	Left side

* See PB 2010-57 for further explanation

Global Surgery Modifiers

Modifier	
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure of other service
58	Staged or related procedure or service by the same physician during the postoperative period
78	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period

Billing requirements for multiple surgeries on the same day have not changed. The first surgery must appear on the first line of the claim; additional surgical procedures must be billed on the next line(s) with modifier 51, "multiple procedures."

Other Modifiers

Modifier	
59	Distinct procedure service

Effective January 1, 2015, CMS is implementing four new HCPCS modifiers as a subset of modifier 59, "Distinct Procedural Service." The new subset of modifiers should be used in lieu of modifier 59 when appropriate to provide greater reporting specificity. These new modifiers will provide a better description of the reason the provider considers the procedure to be separate and distinct.

The four new modifiers are:

• **XE-** *Separate Encounter"*- A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.

• **XS-** *Separate Structure* - A service that is distinct because it was performed on a separate organ/structure.

• **XP-** *Separate Practitioner* - A service that is distinct because it was performed by a different practitioner.

• **XU-** *Unusual Non-Overlapping Service* - The use of a service that is distinct because it does not overlap usual components of the main service.

Like CMS, the Department will continue to recognize modifier 59 after January 1, 2015; however, note that the CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available.

For a complete list of modifiers as well as additional guidance for billing with these modifiers can be found on the DSS Web site. From the Home Page go to "Publications," "Provider Manuals," and select the appropriate provider type from the drop down menu in "Chapter 8, Billing Instructions." Please review this chapter carefully since it contains a more complete description of the allowable modifiers, their descriptions and proper usage.

Further information on NCCI policies can be found in the National Correct Coding Initiative Policy Manual for Medicaid Services. To locate this manual please go to www.medicaid.gov, and then select "Medicaid," then "By Topic," then "Program Integrity," and then select "National Correct Coding Initiative in Medicaid NCCI."

For questions about billing or claims processing, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

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