National Correct Coding Initiative Edits Apply to APG Claims Effective April 1, 2011

As noted in the provider notification at this link: http://www.emedny.org/ProviderManuals/Clinic/PDFS/NCCI_Update_3-11-11.pdf, the Patient Protection and Affordable Care Act ((H.R. 3590) Section 6507 (Mandatory State Use of National Correct Coding Initiative (NCCI)) requires State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems. Effective 4/1/11, hospital clinics, ambulatory surgery centers, and emergency departments and free-standing DOH clinics and free-standing ambulatory surgery centers are subject to the Medicaid NCCI edits. The practitioner NCCI edits apply to ambulatory surgery services and the hospital clinic NCCI edits apply to clinic and emergency department services. The NCCI edits do not apply to free-standing Mental Hygiene (OASAS, OMH and OPWDD) clinic services. The NCCI edits were developed to support national practice, coding and billing standards. NCCI edits prevent inappropriate payment of services that should not be reported together for the same date of service by the same provider; services that are integral to another comprehensive service separately coded; and services that should never be performed with another. In certain circumstances, payment for separate patient encounters, separate anatomic sites or separate specimens is allowed if supported by the medical record and reported with an appropriate modifier.

When two separate and distinct patient encounters are provided by a single provider on the same day, providers will need to code modifier 25 or 59 in addition to the "column two code" to indicate that the second code is separate and distinct. This is especially important when billing for mental hygiene type services. For instance, NCCI prohibits billing both 90846 (family psychotherapy) and 90806 (individual psychotherapy) for the same session, but will allow payment for both codes if modifier 59 is coded along with 90806 indicating that the two codes occurred during separate and distinct sessions. In another instance, NCCI prohibits billing both 99213 (Office or outpatient visit) and 96372 (therapeutic injection) for the same APG visit, but will allow payment if modifier 25 is appended to 99213. However, please note that modifiers may only be appended to HCPCS/CPT codes if clinical circumstances justify use of a modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use.

Additionally, some NCCI edits prohibit coding that is permissible according to APG logic. Code combinations that were previously reimbursable under APG logic but prohibited by NCCI edits will no longer be reimbursable unless an appropriate modifier is properly coded on the claim. Modifiers should not be appended to column 2 procedure codes simply to bypass an NCCI edit.

Please note that the examples provided above are for illustrative purposes only. To ascertain the correct use of modifiers with respect to NCCI edits, please refer to Chapter 1 of the NCCI Coding Policy Manual - General Coding Principles. For further information on modifier use, please consult your HCPCS/CPT book. For NCCI material including the published list of the Medicaid NCCI edits, modifiers and coding guidance, go to: http://www.cms.gov/MedicaidNCCICoding/. Requests to review specific NCCI edits may be submitted by email to dprum@health.state.ny.us; such requests should include the claim TCN and the rationale for payment.