Molina Healthcare of New Mexico, Inc.
Behavioral Health National Correct Coding Initiative

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) is required by the contract held with the State to be compliant in monitoring and editing claims to ensure services are appropriate in scope and amount, and that services are billed in a manner consistent with HSD defined editing criteria and national coding standards.

Therefore, Molina Healthcare has incorporated the National Correct Coding Initiative (NCCI) edits into the current claims system. As claims are processed these edits will fire based on the code combinations submitted on the claim. In addition, these edits may also fire based on codes submitted on other claims that are processed with matching data elements such as dates of service and/or provider information.

It is important to Molina Healthcare that contracted providers understand NCCI Edits, and has prepared the following instructional information regarding these edits.

NCCI Edits

What is the National Correct Coding Initiative (NCCI)?

The Centers for Medicare and Medicaid (CMS) NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together. Molina Healthcare, Inc. utilizes this editing because it is accurate and transparent to our provider community.

What are the Column 1/Column 2 Code Pair Tables?

The NCCI code Pair Tables (located on the CMS website at http://www.medicaid.gov) are used to identify which pairs of codes are subject to NCCI edits. There are two columns. The first column contains the more comprehensive code whereas the column 2 code is identified as a component. These code combinations should not be reported together because they are considered unbundled or mutually exclusive of each other. There are some circumstances in which it may be appropriate to allow payment for both services. In these circumstances HCPCS/CPT modifiers may be appended to identify these circumstances only if the clinical circumstances justify the use of the modifier and the medical documentation clearly supports the circumstance. 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. A complete list of the HCPCS/CPT modifiers that may be valid for NCCI edit override are available on the Medicaid website.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

The NCCI edits in Medicaid

The Affordable Care Act of 2010 required CMS to notify states by September 1, 2010, of the NCCI methodologies that were compatible with Medicaid. The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.

The NCCI Methodologies in Medicaid

The Medicaid NCCI program methodologies that are relevant to Behavioral Health Services are:

1. A methodology with procedure to procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) services.
2. A methodology with PTP edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services).
3. A methodology with MUEs for practitioner and ASC services.
4. A methodology with MUEs for outpatient hospital services for hospitals.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. It is also important to ensure that appropriate diagnosis codes must always be used.

These edits are regularly monitored by the Special Investigation Unit (SIU) to ensure compliance.

Modifier usage is also edited by Molina; it is very important for providers to make sure that they use the correct modifier, on the correct code. For example, Modifier -25 is appropriately used with the Evaluation and Management (E&M) CPT codes, but Modifier -59 is for Non-E&M codes.

Example #1: If documentation and diagnoses billed support codes 90846 and 90847 services on the same day by the same provider, it must be billed appropriately.

Incorrect:
90846 with modifier 59
90847 without a modifier.

Logic:
90846 is the primary code (Column 1), 90847 is a component (Column 2). The component service must be billed with modifier -59.

Incorrect:
90846 without a modifier
90847 with modifier -25

Logic:
Modifier -25 should not be used with a non E&M CPT code. Modifier -59 would be appropriate for this particular code.

Correct:
90846 without a modifier

90847 with modifier -59

Example #2: Claim is received with service code 99214 and 90863 (with or without modifiers)

Incorrect:
These codes are not to be billed by the same provider on the same day.

Logic:
90863 is an add-on code to 90832, 90834, or 90837, but would be considered included with the E&M code, and is therefore never separately reimbursable.

Example #3: If documentation and diagnoses billed support codes 99214 and 90847 services on the same day by the same provider, it must be billed appropriately.

Incorrect:
99214 without a modifier
90847 with modifier -25

Logic:
90847 is the primary code (Column 1), 99214 is a component (Column 2). The component service must be billed with modifier -25, since it is considered an E&M code.

Incorrect:
99214 with modifier -59
90847 without a modifier

Logic:
The component service (99214) must be billed with modifier -25, since it is considered an E&M code.

Correct:
99214 with modifier -25
90814 without a modifier

Molina Healthcare provides a claim reconsideration process for all contracted providers to use should they disagree with Molina Healthcare payment or denial. The process is simple to follow, and allows the provider the opportunity to provide additional information and documentation to support their claim dispute. The 2014 Provider Manual provides detail information on how and when to submit a Provider Reconsideration Review Request (PRR). In addition, your dedicated Behavioral Health Provider Services Team can provide individualized training for office staff on this process. The PRR form is located on our Provider Website at www.molinahealthcare.com

Please contact your dedicated Behavioral Health Provider Services Team toll free at (800) 377-9594 with any questions and/or to request training.

We appreciate the service you provide our Members and thank you for your participation in the Molina Healthcare Provider Network.

Molina Healthcare Behavioral Health Provider Services Team
Molina Healthcare of New Mexico, Inc.