



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
CHARLES J. KROGMEIER, DIRECTOR

## INFORMATIONAL LETTER NO. 875

**DATE:** January 15, 2010

**TO:** Iowa Medicaid Providers Billing on HCFA 1500 Claim Forms

**ISSUED BY:** Iowa Department of Human Services, Iowa Medicaid Enterprise

**RE:** Implementation of Correct Coding Initiative and Compliance with CPT, AMA, and National Coding Guidelines  
Retrospective and Prospective Review of Claims

**EFFECTIVE:** February 1, 2010

In January 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (NCCI) in the Medicare program. The use of Correct Coding Initiative (CCI) edits is mandatory in the Medicare program. These edits are applicable to the Medicaid program since they are based on general correct coding principles.

In our ongoing efforts to improve performance in claims processing and payment, we are implementing CCI as part of our claims processing program to enhance our current platform. CCI is virtually the same type of controls that we place in our current claims processing system and review as part of our regular surveillance and utilization review. Iowa Medicaid will now be able to ensure a more thorough and comprehensive review of all claims in compliance with CMS. We will base all edits on open, public sources provided by CMS and The American Medical Association with the adoption of the CCI. This will allow for a more consistent and transparent processing and payment of claims and will ensure the Department of Human Services is in compliance with national and state standards. Medicaid will only differ from Medicare in circumstances where Medicaid pays for a service that Medicare does not cover. An example of this would be for certain preventative or wellness services that Medicare does not cover. Iowa Medicaid will continue to cover these services under state policy and rule.

The Iowa Medicaid Enterprise will implement the CCI effective February 2010. Iowa Medicaid will adopt national coding policies that are already being used by Medicare, other payers, and the provider community. This change may affect any provider who bills for services using Current Procedure Terminology (CPT) or HealthCare Common Procedure Coding System (HCPCS) and submits claims on a HCFA 1500. The enhanced editing will include identification of claims where coding methods do not adhere to guidelines established by CMS. The CCI implementation will include edits for services that are mutually exclusive and should not be reported together, as well as component code edits. As always, procedures should continue to be reported with the most comprehensive CPT code that describes the service(s) being performed. Multiple codes should not be used when a single comprehensive code is available.

Under specific circumstances, providers will need to indicate that a procedure or service was distinct, separate or independent from other services performed on the same day. Certain modifiers may be appropriate to represent different sessions or patient encounters. Correct use of NCCI modifiers will be monitored and should NOT be used to bypass an edit unless the proper criteria for the use of the modifier is met. Providers will be required to have documentation in the medical record to satisfy the criteria required to support the use of any NCCI associated modifier.

One significant change that Iowa Medicaid will implement is to align with Medicare on the global surgical package. This is the time periods when the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. Currently Iowa Medicaid follows the global surgical time period of zero or fourteen post-operative days. Beginning February 2010, Iowa Medicaid will change the global surgical time period to 0-10-90, consistent with Medicare's global surgical package. All claims for dates of service after January 31, 2010 will pay in accordance with this edit rule requiring the use of an appropriate modifier to indicate if a separate unrelated E/M service was provided during the global surgical time period.

Providers should consult the National Correct Coding Initiative (NCCI) for more information regarding the proper use of modifiers and correct coding. The NCCI information can be found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

As part of this implementation, we are conducting a review on previously paid claims to ensure coding compliance with the Department of Human Services billing policies that were in effect during the reviewed time period. The retrospective review *will not* look at the use of modifiers on claims where the State did not require modifiers for claim payment in the past. Areas of our review will be based on the following globally accepted coding principals that were the state's policy during the retrospective review time period.

- 1) **Duplicates:** Duplicates occur when an identical claim line for the same date of service by the same provider is received on a new claim with a different claim number. These also can include lifetime duplicates where a procedure can only be billed once per lifetime (i.e. hysterectomy, autopsy) and date range duplicates where a procedure can only be billed a specific number of times within a defined time frame (i.e. pacemaker insertion/replacement).
- 2) **Incidental Procedures:** This category of edits identifies procedure codes classified as not payable due to being bundled in another service or excluded in the CMS National Physician Fee Schedule Relative Value File.
- 3) **CCI:** Comprehensive- These procedure codes have been identified as inappropriate unbundling of comprehensive procedure codes into its component parts (codes).

Mutually Exclusive-These procedure codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.

- 4) **Multiples Units:** Billing excessive number of units on the same day or those procedures where the American Medical Association (AMA) and CPT allow no more than one unit of service per day.
- 5) **Global Surgery:** In accordance with the State of Iowa's policy (0-14) of defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code.

After January 30, 2010, Iowa Medicaid will apply CMS, CCI edits to ensure that coding for services is appropriate. Iowa Medicaid is confident that with your help the improved claims review process with the prospective CCI implementation will ensure that appropriate services are delivered and paid correctly in accordance with state and federal policy and regulations. By working together we can ensure the most efficient use of limited health care dollars and ensure accurate and timely processing and payment of claims.

If you have any questions, please contact IME Provider Services: 1-800-338-7909, locally 515-725-1004 or by e-mail at [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us). Additional information regarding the National Correct Coding Initiative can be found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.