

Questions and Answers regarding National Correct Coding Initiative (NCCI) Claims Edits and related
Indiana Medicaid claims denials

- 1.) For claims with dates of service 10/01/2010 through 1/27/2011:
 - a. Should only “Denied Claims” for this time period be voided and re-billed?
- OR -
 - b. Should all affected claims for this time period be voided and re-billed?

This is the range of service dates that will be mass adjusted starting March 14th. Since Indiana Medicaid was not able to implement required NCCI changes until 01/27/2011, claims with dates of service during this “retroactive period” will be reprocessed, subject to NCCI editing. If you have claims in this period that should have been billed with a modifier when group and individual therapy services were rendered to the same patient on the same day (the 59 modifier is required if separate and distinct therapy services are provided to the same patient on the same day), then you will need to void and rebill the claim with the appropriate modifier. If this is done before Medicaid does a mass adjustment (claims reprocessing with NCCI edits) beginning March 14th, your claims should not be affected.

- 2.) For claims with dates of service 1/27/2011 through March 2,2011 that have already been submitted:
 - a. Should only “Denied Claims” for this time period be voided and re-billed?
- OR -
 - b. Should all affected claims for this time period be voided and re-billed?

Keep in mind that, after 1/27/2011, ALL claims with dates of service from 10/01/2010 forward are subject to NCCI editing. If the claim denied completely, you should just rebill since you cannot void a claim that does not have any payments. When NCCI editing was implemented on 01/27/2011, you could possibly have received NCCI edit denials for certain claim details. These must be reviewed to ensure the Medicaid member/patient received “separate and distinct” services on the same day. If so, void and rebill the services using correct codes/modifiers on a new claim.

- 3.) Should modifier 59 be used with all CPT codes for both initial and subsequent services provided on the same day by the same provider, or should only the subsequent services be billed with modifier 59 (thus, the initial service would be reported without modifier 59 and only additional services provided that day reported with modifier 59)?

Please see the NCCI bulletin (#BT 201036) on the www.indianamedicaid.com website. This bulletin refers providers to the CMS website for reporting of codes. This guidance indicates that when two separate and distinct therapy services are provided to the same patient on the same day, the subsequent separate and distinct service should be billed with the 59 modifier. Use the modifier in conjunction with only one of the two codes.

- 4.) Use of the term “Provider” – The Modifier 59 Article and associated support documentation / manuals refer to the individual “Provider”, with the primary example of “The Physician”. Since schools are the single “Provider”, claims are not reported by individual “rendering provider”/clinician (i.e., Speech Therapist); but rather, all services are claimed using one (the school corporation’s) Medicaid provider number (individual clinician service logs identify the rendering provider although this information is not

submitted on the Medicaid claim). Does modifier 59 apply to services provided by separate individual clinicians within the school on the same day? For example, the SLPA may provide group services in the class room in the morning, and the SLP later provides individual services in the afternoon. In this example, would modifier 59 be utilized, and if so, would it be used for the SLPA group service while the SLP individual service would be reported without modifier 59?

Since school corporation providers bill with the school provider number and are not required to report the rendering provider number on the claim detail, there is no indication that it matters which detail is billed using the 59 modifier.