Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2017-69**
www.ctdssmap.com **October 2017**

TO: Physicians, Advanced Practice Registered Nurses (APRN), Certified Nurse Midwives (CNM), Physician Assistants (PA), Rehabilitation Clinics, Family Planning Clinics, , Optometrists, Psychologists, Podiatrists, Independent Laboratories, Independent Therapists, Independent Radiology Providers, Medical Equipment Devices and Supplies (MEDS) Providers, Ambulatory Surgery Centers, Naturopaths, Chiropractors, Outpatient Hospitals and Chronic Disease Hospitals

RE: National Correct Coding Initiative (NCCI) – Medically Unlikely Edits Review Process

---

The Department of Social Services (DSS) is implementing a process for reviewing claims denied solely due to exceeding the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) limit for dates of service July 1, 2016 and forward.

A Medicaid NCCI MUE edit is a unit of service claim edit that defines the number of units of service beyond which the reported number of units of service is unlikely to be correct for certain Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes. MUEs are based on quarterly NCCI updates received from the Centers for Medicare and Medicaid Services (CMS).

Medicaid NCCI edit files are available on the www.medicaid.gov Web site. From this page, go to "Medicaid", then to "Program Integrity", and then select "National Correct Coding Initiative (NCCI)".

DSS Review

Providers can request DSS review of claims with denied details due to exceeding an MUE with Explanation of Benefits (EOB) Code 770 "MUE Units Exceeded". Claim details over the assigned MUE limit will be denied even if there is an approved prior authorization (PA) that would otherwise allow coverage of the service.

If a claim denies **solely** due to exceeding the NCCI MUE limit, providers may submit a request to have the claim reviewed.

An electronic claim must be submitted following the guidelines set forth in Provider Bulletin 2017-49, "Electronic Claim Submission with Paper Attachment Process" for an MUE review. It must list all the services rendered on the denied claim. The detail that exceeded the allowed MUE must be broken out into two separate details. The first detail line should be submitted with the allowed MUE units and the remaining units must be submitted on a separate detail with the GD modifier. The electronic claim will be suspended for review.

In order for a claim to be reviewed, the following information must be submitted as a paper attachment:

- a cover letter containing the original Internal Control Number (ICN) and written correspondence explaining the reason for the appeal; and
- any other information that will support a determination by the Connecticut Medical Assistance Program (CMAP) that the service for which payment denied is medically necessary.

The information must be faxed or mailed to DXC Technology following the instructions for submitting paper attachments in Provider Bulletin 2017-49.

Overriding the MUE limit does not guarantee payment. The provider must also demonstrate that the claim was properly completed and submitted in accordance with all CMAP requirements, and that all other prerequisites for payment have been met. **Claims that have exceeded the timely filing limits may not be submitted for review.**

Outpatient Hospitals

Procedure codes assigned an Ambulatory Payment Classification (APC) status indicator that is considered packaged or non-payable should not be submitted for review. Hospitals should reference CMAP's Addendum B via www.ctdssmap.com by selecting the "Hospital Modernization" Web page. CMAP's Addendum B (Excel) is located under "Important Messages – Connecticut Hospital Modernization".

Claim Examples

Example	DOS	RCC	Units	Procedure Code	Modifiers	Billed Amt.	Paid Amt.	EOB
Detail 1	**9/1/2017**	**335**	**5**	**96411**		**$100.00**	**$0.00**	**770**
Detail 2	**9/1/2017**	**450**	**1**	**99283**		**$375.00**	**237.56**	
Re-submitted Claim								
Detail 1	**9/1/2017**	**335**	**2**	**96411**		**$40.00**		
Detail 2	**9/1/2017**	**335**	**3**	**96411**	**GD**	**$60.00**		**772**
Detail 3	**9/1/2017**	**450**	**1**	**99283**		**$375.00**		

MUE units for procedure code 96411 is 2 and the re-submitted claim will suspend with EOB code 772 - "Unit of Service > MUE and Claim Paid/Denied after Policy Review".

*The original claim should be voided and the claim should be re-submitted electronically following the guidelines set forth in Provider Bulletin 2017-49 when the provider wants the claim to be reviewed for MUE units.