

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

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Medically Unlikely Edits (MUEs)

The Affordable Care Act (ACA) of 2010 requires state Medicaid programs to incorporate NCCI (National Correct Coding Initiative) methodologies in their systems for processing Medicaid claims by October 1, 2010. The NCCI promotes national correct coding methodologies and reduces improper coding with may result in inappropriate payments of Medicaid claims.

The NCCI contains two types of edits:

- Procedure-to-procedure (PTP) edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons, to prevent improper payments
- Medically Unlikely Edits (MUEs) define for HCPCS/CPT codes the maximum units of service (UOS) that a provider would report under most circumstances for a single member on a single date of service.

Reported units of service greater than the MUE value are unlikely to be correct (for example: a claim for more than one appendectomy or excision of more than one gallbladder). Billed claim lines with a unit-of-service (UOS) greater than the established MUE value for the HCPCS / CPT code are denied payment in their entirety.

CMS provides the Medicaid NCCI edit files for downloading on a quarterly basis.

AHCCCS follows the CMS Correct Coding Initiative and performs CCI edits on FFS claims for the same provider, same recipient, on the same date of service. If providers bill for more units of service than the MUE value, the claim line will deny and remit will show edit code L207. (For 835 file, L207 would be mapped to the HIPAA compliant edit; however, the L207 edit code is present on the web claim inquiry on-line.)

The provider must rebill the claim with the correct UOS to avoid the MUE edit denial.

Revised NEMT Trip Report and Instructions

On the NEMT Trip Report form the “Reason for visit” section has been updated to remove the language “be specific”. The recipient is not required to share Protected Health Information (PHI) and does not have to give more information than they are comfortable sharing.

Please advise staff and drivers to be considerate and respectful – the recipient has the right to keep their health information private. For example, if they only say that the transport is for a “doctor visit” or “clinic visit” then do not insist on more detail if none is offered.

In addition, transportation cannot be refused if the recipient chooses not to share health information details.

The NEMT Trip Report form and the Instructions have been updated and are available on the AHCCCS website.

Reminder: Paper Claim Submissions

Paper claims submitted to the AHCCCS Administration should not contain handwriting or stamps on the claim. When these items are placed on a claim it is unable to be accurately scanned into our imaging system and will create a delay in processing your claim for payment.

As a reminder, claims can be submitted to the AHCCCS Administration for Fee-for-Service recipients via the AHCCCS on-line web portal and through an 837 transaction, eliminating the need to print and mail claims and resulting in a quicker payment turnaround.

Provider Registration Changes for Provider Type 40 *Correction*

Effective 6/01/2015 providers registering as a provider type 40 (Attendant Care Agency) will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services. Upon completion of the 12 month period this provider type will be able to bill for NEMT services. However, the NEMT services should not exceed 20% of the overall services billed.