

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**GEORGIA DID NOT PAY SOME LINE
ITEMS ON MEDICAID CLAIMS IN
ACCORDANCE WITH ITS MEDICAID
NATIONAL CORRECT CODING
INITIATIVE METHODOLOGIES**

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Deputy Inspector General

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Georgia did not pay some line items in accordance with its Medicaid National Correct Coding Initiative methodologies on claims that hospitals submitted. As a result, Georgia made erroneous payments to providers totaling approximately \$1 million (Federal share).

WHY WE DID THIS REVIEW

Since 1996, the National Correct Coding Initiative (NCCI) methodologies have saved Medicare millions of dollars in expenditures. Federal law mandates that States incorporate compatible NCCI methodologies into their Medicaid program systems for claims filed on or after October 1, 2010. Georgia Department of Community Health (State agency) implemented the Medicaid-compatible NCCI payment methodologies (Medicaid NCCI) for claims filed on or after November 1, 2010, and did not report any incompatibilities between Georgia's Medicaid program and the Medicaid NCCI. We performed preliminary data matches that indicated that the Medicaid NCCI may not have been properly implemented.

The objective of our audit was to determine whether the State agency paid line items in accordance with its Medicaid NCCI methodologies on claims that hospitals submitted from November 1, 2010, through September 30, 2011.

BACKGROUND

In January 1996, the Centers for Medicare & Medicaid Services (CMS) implemented the NCCI, a program that consists of coding policies and automatic computer edits. The NCCI's purpose is to promote correct Healthcare Common Procedure Coding System (HCPCS) coding of health care services provided to Medicare beneficiaries and to prevent Medicare payment for improperly coded services. The NCCI edits identify HCPCS codes for services that, under Medicare coding and payment policy, ordinarily should not be billed for the same patient on the same day (HCPCS code pairs).

On September 1, 2010, CMS notified States that the Medicare NCCI methodologies were compatible with Medicaid. CMS therefore required the States to incorporate the NCCI edit methodologies into their Medicaid claims processing systems and to begin editing claims filed on or after October 1, 2010.

In Georgia, the State agency administers the Medicaid program. The State agency implemented the Medicaid NCCI in the Georgia Medicaid Management Information System (GAMMIS), a computerized payment and information reporting system, effective November 1, 2010. (CMS had given an extension to the October 1st deadline.) The State agency contracted with its fiscal agent to implement the Medicaid NCCI.

WHAT WE FOUND

The State agency did not pay some line items in accordance with its Medicaid NCCI methodologies on claims hospitals submitted from November 1, 2010, through September 30, 2011. Overall, the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI into GAMMIS on schedule. However, the Medicaid NCCI edits did not prevent erroneous payments. The State agency made erroneous payments to providers totaling \$1,490,956 (\$1,040,352 Federal share).

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in GAMMIS approved only comprehensive HCPCS codes when they were reported with component codes (already included in the comprehensive code) for the same date of service. The State agency acknowledged that the Medicaid NCCI edits did not work as intended and that it paid line items in error. Subsequent to our fieldwork, agency officials stated that all of the erroneous payments identified in our universe have been recovered from providers.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund erroneous payments totaling \$1,040,352 to the Federal Government and
- ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the GAMMIS.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency concurred with our recommendations and described the corrective actions it had taken.

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INTRODUCTION

WHY WE DID THIS REVIEW

Since 1996, the National Correct Coding Initiative (NCCI) methodologies, which include policies for coding Medicare services and automatic computer edits to review those coded services, have saved Medicare millions of dollars in expenditures. Federal law mandates that States incorporate compatible NCCI methodologies into their Medicaid program systems for claims filed on or after October 1, 2010.¹ The Georgia Department of Community Health (State agency) implemented the Medicaid-compatible NCCI payment methodologies (Medicaid NCCI) for claims filed on or after November 1, 2010, and did not report any incompatibilities between Georgia's Medicaid program and Medicaid NCCI. Before initiating this review, we performed preliminary data matches, which indicated that Medicaid NCCI may not have been properly implemented.

OBJECTIVE

Our objective was to determine whether the State agency paid line items in accordance with its Medicaid NCCI methodologies on claims that hospitals submitted from November 1, 2010, through September 30, 2011.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Providers of Medicaid services submit claims to States to receive compensation. The States process and pay the claims. The Federal Government pays its share of a State's medical assistance costs (Federal share) under Medicaid on the basis of the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

¹ Because of the technical and financial challenges of updating State Medicaid Management Information Systems (MMISs), CMS provided flexibility in the implementation deadline and continued to work with States beyond the statutory date. (See page 14 of the U.S. Department of Health and Human Services, *Report to Congress on Implementation of the NCCI in the Medicaid Program as Required by Section 6507 of the Affordable Care Act* (March 1, 2011).)

National Correct Coding Initiative

In January 1996, CMS implemented the NCCI, a program that consists of coding policies and automatic computer edits. The NCCI's purpose is to promote correct Healthcare Common Procedure Coding System (HCPCS)² coding of health care services provided to Medicare beneficiaries and to prevent Medicare payment for improperly coded services. The NCCI contains automated edits that identify claim submissions in which a provider bills more than one service for the same beneficiary for the same date of service. The NCCI edits then identify HCPCS code pairs for services that, under Medicare coding and payment policy, ordinarily should not be billed for the same patient on the same day.³

CMS was required to determine which Medicare NCCI methodologies were compatible with Medicaid and to notify States of the methodologies to be incorporated into their MMIS. States had to apply those Medicaid-compatible methodologies for claims filed on or after October 1, 2010 (section 1903(r)(1)(B)(iv), as amended). On September 1, 2010, CMS issued a State Medicaid Director letter (#10-017) notifying States of five Medicaid NCCI methodologies and providing files⁴ and instructions on how to incorporate them into their MMISs.

Medicaid National Correct Coding Initiative Methodologies

The Medicaid NCCI methodologies have four components: (1) a set of edits, (2) a set of definitions of types of claims subject to the edits, (3) a set of claim-adjudication rules for applying the edits, and (4) a set of rules for addressing provider and supplier appeals of payments denied because of the edits.

One type of Medicaid NCCI edit is called a “comprehensive and component” edit.⁵ This type of edit identifies HCPCS code pairs that should not be billed together because one code (the component code) identifies a service inherently included in the other (the comprehensive code). If a provider bills for a comprehensive service together with a component service for the same beneficiary and on the same date of service, the State should ordinarily pay only the service with

² Providers report procedures and services performed on Medicare beneficiaries using HCPCS codes.

³ The NCCI is based on coding conventions defined in the American Medical Association's *Current Procedural Terminology Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice. NCCI edit tables are derived from these reference sources. The NCCI contains two types of prepayment edits tables: Column 1/Column 2 Correct Coding Edits tables (edits tables) and the Mutually Exclusive Edits table. We only applied the Column 1/Column 2 edits tables during this audit. (We refer to these as comprehensive and component edits.) The Column 1/Column 2 edits tables contain the following six columns: (1) the payable code, (2) the code that is not payable when reported with the column 1 code, (3) the edit existence date, (4) the edit effective date, (5) the edit deletion date, and (6) whether the use of a modifier is permitted. NCCI edit tables are updated quarterly.

⁴ The Medicaid NCCI files contain the different edits tables that State Medicaid programs must incorporate into their MMIS.

⁵ This type of edit is also referred to as “procedure-to-procedure” and “column 1/column 2.”

the comprehensive code.⁶ Only under certain circumstances, a provider may include a modifier line item to indicate that payment of both services in a comprehensive and component HCPCS code pair is allowable.

Georgia's Implementation of Medicaid National Correct Coding Initiative Methodologies

In Georgia, the State agency administers the Medicaid program. The State agency implemented the Medicaid NCCI in the Georgia Medicaid Management Information System (GAMMIS), a computerized payment and information reporting system, effective November 1, 2010. The State agency contracted with its fiscal agent to implement the Medicaid NCCI. The State agency notified providers through its GAMMIS Web portal that it had incorporated Medicaid NCCI edits in GAMMIS and that those edits would be applied to claims.⁷

HOW WE CONDUCTED THIS REVIEW

From CMS's Medicaid Statistical Information System (MSIS), we obtained approximately 5 million line items⁸ that the State agency paid to hospitals from October 1, 2010, through September 30, 2011, totaling approximately \$355 million for outpatient services. We did not review line items that did not contain a HCPCS code; had a length of service of greater than 1 day; or did not match to any other line item submitted for payment by the same provider for the same beneficiary on the same date of service (i.e., line items with no code pair). Instead, to determine the line items to review, we created a code pair data file by identifying (1) HCPCS codes paid on each line item and (2) other HCPCS codes that were submitted on a previous, the same, or a later claim that contained the same (a) date of service, (b) provider, and (c) beneficiary as the original line item.

In addition, after comparing the code pairs with the Medicaid NCCI edit tables, we removed line items that (1) matched to an edit that had an effective date outside of the HCPCS code service date or before the implementation date of November 1, 2010, and (2) contained an allowable modifier. From the remaining 25,085 line items, totaling \$1,490,956 (\$1,040,352 Federal share), we selected a random sample of 30 line items to validate our match and that the State agency paid for the services of both line items in the HCPCS code pair.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

⁶ Although the column 2 code is often a component of a more comprehensive column 1 code, this relationship is not true for many edits. In those cases, the code pair represents two codes that should not be reported together unless an appropriate modifier is used.

⁷ Hospitals must code outpatient services on claims submitted to the State agency using HCPCS codes. When a single code is available for reporting multiple tests or procedures, that code must be used rather than reporting the tests or procedures individually (*Georgia Department of Community Health, Division of Medicaid, Policy and Procedures for Hospital Services*, Part II, ch. 900, § 902.3 (January 1, 2013)).

⁸ A line item represented an individual service billed as part of a claim for a Medicaid beneficiary.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, and Appendix B contains the results of our review of all 30 line items in our sample.

FINDINGS

The State agency did not pay some line items in accordance with its Medicaid NCCI methodologies on claims Georgia hospitals submitted from November 1, 2010, through September 30, 2011. Overall, the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI edits into GAMMIS on schedule. However, the Medicaid NCCI edits did not prevent erroneous payments. The State agency made erroneous payments to providers totaling \$1,490,956 (\$1,040,352 Federal share).

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in GAMMIS approved only comprehensive HCPCS codes when they were reported with component codes for the same date of service. The State agency acknowledged that the Medicaid NCCI edits did not work as intended and that it paid line items in error.

THE STATE AGENCY PAID SOME LINE ITEMS THAT WERE NOT IN ACCORDANCE WITH MEDICAID NATIONAL CORRECT CODING INITIATIVE METHODOLOGIES

Federal law required that States incorporate Medicaid-compatible methodologies of the Medicare NCCI edits into the MMIS by October 1, 2010. Georgia implemented the Medicaid NCCI edits into its MMIS and began editing claims against the Medicaid NCCI edits tables effective for claims filed on or after November 1, 2010. (CMS had given an extension to the October 1st deadline.) (See Appendix C for Federal and State requirements.)

The State agency incorrectly paid some line items that were not in accordance with Medicaid NCCI methodologies. Although the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI edits into its MMIS on schedule, the comprehensive and component edits contained in the implemented Medicaid NCCI did not prevent erroneous payments. We identified a population of 25,085 component code line items that were reported on the same claim as a comprehensive code and so may have been erroneously paid. We selected a random sample of 30 line items to validate our data match and determined that all of the 30 line items included erroneous payments to providers. The table shows examples of comprehensive and component codes reported on the same claim for the same beneficiary and date of service.

Table: Examples of Comprehensive and Component Codes Reported Together

Comprehensive Code and Description	Component Code and Description	Same Provider, Beneficiary, and Date of Service?	Date of Service
33213 Insertion of Pulse Generator	93005 Electrocardiogram Tracing	Yes	November 12, 2010
51702 Insertion of Temporary Bladder Catheter	96374 Therapeutic, Prophylactic, or Diagnostic Injection	Yes	March 22, 2011
96413 Chemotherapy Intravenous Infusion	99213 Office Outpatient Visit	Yes	May 17, 2011

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in GAMMIS approved only comprehensive HCPCS codes when they were reported with component codes for the same date of service. State agency officials acknowledged that the Medicaid NCCI edits did not work as intended and that the State agency paid the resulting line items in error. Subsequent to fieldwork, agency officials have stated that all of the erroneous payments identified in our universe have been recovered from providers.

CALCULATION OF UNALLOWABLE FEDERAL REIMBURSEMENT FOR THE ERRONEOUS PAYMENTS

On the basis of our data analysis, the 100-percent error rate of our sample, and Federal requirements to implement the Medicaid NCCI on Medicaid claims, we concluded that the State agency made erroneous payments to providers for 25,085 line items, totaling \$1,490,956 (\$1,040,352 Federal share). Using the applicable FMAP,⁹ we calculated the FMAP amount that the State agency associated with the Medicaid paid amount for the component HCPCS code for each of the 25,085 line items. (See Appendix D for our calculation of this overpayment.)

⁹ The FMAP is used to determine the amount of Federal share for specified State expenditures for assistance payments under the Act. The FMAP rates were temporarily increased from October 1, 2008, through December 31, 2010 (section 5001 of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5). The FMAP increases were extended until June 30, 2011.

RECOMMENDATIONS

We recommend that the State agency:

- refund erroneous payments totaling \$1,040,352 to the Federal Government and
- ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the GAMMIS.

STATE AGENCY COMMENTS

In comments on our draft report, the State agency concurred with our recommendations and described the corrective actions it had taken. The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 25,085 line items¹⁰ with payments totaling \$1,490,956 (\$1,040,352 Federal share) for services performed from November 1, 2010, through September 30, 2011. We limited our review to determining whether Medicaid NCCI edits should have applied to the selected line items. We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We did not question the medical necessity of any of the services provided or their eligibility for Medicaid reimbursement.

We conducted our audit from August 2012 to November 2012 and performed our fieldwork at the State agency's office in Atlanta, Georgia.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed Federal and State laws, regulations, and guidance and the State plan.
- We held discussions with State agency officials to understand their policies and controls for Medicaid NCCI methodologies.
- We conducted survey work at a hospital in Georgia and at the State agency to understand how the Medicaid NCCI was implemented at hospitals within the State.
- We identified a sampling frame of 25,085 line items with payments totaling \$1,490,956 (\$1,040,352 Federal share) by performing the following steps:
 - We downloaded a database from CMS's MSIS that contained 4,847,974 line items with payments totaling \$354,905,555.
 - We removed the following 1,861,579 line items with payments totaling \$147,902,598 from the MSIS data:
 - 1,201,299 line items that did not include a HCPCS code;
 - 648,118 single line item claims that did not match to any other line item by provider, beneficiary, and date of service; and
 - 12,162 line items for claims with a length of service of greater than 1 day.

¹⁰ A line item represented an individual service billed as part of a claim for a Medicaid beneficiary.

- Using computer programming, we created a “coding pair data file”¹¹ that compared the remaining 2,986,395 line items with other line items for the same (a) date of service, (b) provider, and (c) beneficiary. This data match identified 9,359,585 code pairs.
- We matched the 9,359,585 code pairs in our coding pair data file to the Medicaid NCCI edit tables that were effective from October 1, 2010, through September 30, 2011 (active NCCI code pairs). This data match identified 68,235 pairs of line items in our coding pair data file that matched NCCI code pairs.
- For each pair of line items that matched the Medicaid NCCI, we created one sampling unit consisting of the line item HCPCS code that is not payable (the component code of the code pairs)¹² and the dollars associated with it.
- From the 68,235 line items, we removed (1) 6,498 line items that matched to a Medicaid NCCI edit that had an effective date after the HCPCS service date or before the Medicaid NCCI methodologies’ implementation date of November 1, 2010,¹³ and (2) 36,652 line items matched to a Medicaid NCCI edit with a modifier indicator of “1.”
- To validate that the remaining 25,085 line items totaling \$1,490,956 were erroneously paid, we:
 - used simple random sampling to select a sample of 30 line items from the sampling frame of 25,085 line items,
 - used the State agency’s MMIS to determine whether Medicaid paid for both HCPCS codes of the code pair for each of the 30 sampled items,
 - determined whether the sampled items had been adjusted, and
 - determined whether the State agency had applied the Medicaid NCCI edits to the 30 sampled items.

¹¹ The coding pair data file contains two columns (comprehensive and component), and each row in that file contains two HCPCS codes (code pairs). The number of code pairs identified exceeded the number of remaining line items because the code pair data file contained all possible combinations of HCPCS codes that providers submitted for the same beneficiary on the same date of service.

¹² The HCPCS code identified as not payable was in the component column of the edits tables. For example, a hospital should not report an insertion of a pulse generator code (comprehensive column) and an electrocardiogram tracing code (component column) together. In this case, the component code is included in the comprehensive code and should not be paid.

¹³ We did not review line items with a service date before the Medicaid NCCI implementation date of November 1, 2010.

- To determine the Federal share of the 25,085 erroneously paid line items, we:
 - obtained from the State agency the eligibility records for the sampling frame line items,
 - identified the Medicaid Codes of Eligibility¹⁴ from the eligibility records,
 - obtained the quarterly FMAP rates for the *Medicaid Codes of Eligibility for Federal FY 2011*,
 - matched the FMAP rates to the sampling frame line item using the line item's adjudicated payment date, and
 - quantified the Federal overpayment by multiplying the nonpayable (component) HCPCS code paid amount by the applicable FMAP rate.

- We discussed the results of our review with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁴ The *Medicaid Codes of Eligibility for Federal FY 2011* identifies the reason the beneficiary is eligible for Medicaid. The applicable FMAP is determined on the basis of a beneficiary's reason for Medicaid entitlement.

**APPENDIX B: LINE ITEM DETAIL—COMPREHENSIVE
AND COMPONENT CODES**

Comprehensive Code	Component Code	Same Provider, Beneficiary, and Date of Service?	Date of Service
10060	96375	Y	February 3, 2011
97598	29581	Y	March 14, 2011
31500	36600	Y	January 25, 2011
31720	93005	Y	April 11, 2011
33213	93005	Y	November 12, 2010
36600	96372	Y	November 2, 2010
44970	93005	Y	June 20, 2011
51702	96374	Y	March 22, 2011
52353	96360	Y	June 8, 2011
52353	96374	Y	March 21, 2011
76819	59025	Y	June 8, 2011
74160	96374	Y	November 4, 2010
74160	96374	Y	November 19, 2010
93975	76700	Y	April 8, 2011
92980	93005	Y	December 22, 2010
92980	93555	Y	November 10, 2010
94010	94375	Y	March 7, 2011
94060	94640	Y	February 14, 2011
94640	94664	Y	November 2, 2010
94640	94664	Y	February 26, 2011
94640	94664	Y	March 1, 2011
94760	94762	Y	December 31, 2010
96365	96360	Y	April 18, 2011
96360	96374	Y	November 27, 2010
96360	99218	Y	March 31, 2011
96365	96374	Y	April 17, 2011
96374	96372	Y	November 9, 2010
96413	99213	Y	May 17, 2011
96413	99213	Y	December 6, 2010
99218	99285	Y	January 14, 2011

APPENDIX C: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Pursuant to section 1903(r)(4) of the Act, on September 1, 2010, CMS issued State Medicaid Director Letter 10-017, *National Correct Coding Initiative*, which:

- identified and notified States of NCCI methodologies that are “compatible” with Medicaid claims filed to promote correct coding and to control improper coding leading to inappropriate payment of claims under Medicaid,
- notified States of the NCCI methodologies (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) that should be incorporated for claims filed with Medicaid for which no national correct coding initiative methodology has been established for Medicare, and
- informed States how they must incorporate these methodologies for claims filed under Medicaid.

Section 1903(r)(1)(B)(iv) of the Act requires that States incorporate compatible methodologies of the NCCI administered by the Secretary of Health and Human Services and such other methodologies as the Secretary identifies effective for Medicaid claims filed on or after October 1, 2010.

Pursuant to 42 CFR § 433.10, the Federal Government reimburses the State for its share (Federal share) of State medical assistance expenditures according to a defined formula. However, the States are responsible for recovering from providers any amount paid in excess of allowable Medicaid amounts and for refunding the Federal share to CMS (42 CFR § 433.312).

STATE REQUIREMENTS

Although Georgia does not have a State regulation regarding the implementation of the Medicaid NCCI, it did implement the Medicaid NCCI by notifying providers through its GAMMIS Web portal that it had incorporated Medicaid NCCI edits and would apply those edits to claims filed on or after November 1, 2010.

APPENDIX D: CALCULATION OF UNALLOWABLE FEDERAL REIMBURSEMENT

Period	Total Medicaid Payment	Federal Medical Assistance Percentage	Unallowable Federal Reimbursement
Nov 1, 2010– Dec 31, 2010	\$109,893	75.16	\$82,595
Nov 1, 2010– Dec 31, 2010	1,693	75.73	1,282
Nov 1, 2010– Dec 31, 2010	932	100.00	932
Jan 1, 2011– Mar 31, 2011	393,341	72.33	284,504
Jan 1, 2011– Mar 31, 2011	5,070	75.73	3,840
Jan 1, 2011– Mar 31, 2011	1,726	100.00	1,726
Apr 1, 2011– Jun 30, 2011	493,614	70.45	347,751
Apr 1, 2011– Jun 30, 2011	3,067	75.73	2,323
Apr 1, 2011– Jun 30, 2011	237	100.00	237
Jul 1, 2011– Sep 30, 2011	476,102	65.33	311,037
Jul 1, 2011– Sep 30, 2011	4,707	75.73	3,565
Jul 1, 2011– Sep 30, 2011	143	90.00	129
Jul 1, 2011– Sep 30, 2011	431	100.00	431
Total	\$1,490,956		\$1,040,352¹⁵

¹⁵ We estimated the total sum to the nearest dollar.

APPENDIX E: STATE AGENCY COMMENTS



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

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October 24, 2013

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Office of Inspector General
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REPORT NUMBER: A-04-12-06159

Dear Ms. Pilcher:

This letter is in response to the draft 'revised' report received on September 30, 2013, from the Region IV Office of Inspector General (OIG) office labeled as 'Georgia Did Not Pay Some Line Items on Medicaid Claims in Accordance With Its Medicaid National Correct Coding Initiative Methodologies.' We are responding to the OIG/HHS revised audit report regarding identified overpayments found in the sampling of outpatient hospital claims related to column one and column two Procedure to Procedure (PTP) co-pairs. We appreciate the re-review and notification by the OIG/HHS Region IV office of GA Medicaid's original audit findings and CMS' discussion with the OIG/HHS auditors of the PTP audit methodology.

The following responses again summarize our concurrence or non-concurrence to the same two recommendations that OIG recommended previously to Georgia Medicaid for comment:

OIG Recommendation: Refund erroneous payments totaling \$1,040,352.00 to the Federal Government.

Georgia's Response: Georgia Medicaid concurs with the above 'revised' OIG recommendation of payment for the above federal share. Georgia Medicaid acknowledges that the Medicaid NCCI edits in the GAMMIS erroneously paid the line items in the PTP co-pairs in OIG's sample of outpatient hospital claims. OIG/HHS auditors revised the overstated payment amount as previously provided from the state's claims data.

Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan

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OIG Recommendation: Ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the GAMMIS.

Georgia's Response: Georgia Medicaid concurs with this OIG recommendation. On 27 September 2012, the PTP files for all outpatient hospital providers, professional and ambulatory service center providers were fully implemented by the state's fiscal agent in accordance to the NCCI edits per CMS' directive. Therefore, since the 2012 OIG audit, the GAMMIS is fully incorporated with the quarterly PTP files and with the NCCI claims' edits functioning properly.

Thank you for providing a revised draft report of Georgia Medicaid's overpayment for the federal share and its audit findings for the PTP co-pairs and NCCI edits. If you should have any further questions or need further clarification, please contact either Ms. Heather Bond, Deputy Chief, Policy and Provider Services at (404) 657-1502 or via e-mail at hbond@dch.ga.gov or Ms. Argartha Russell, Director, Medical Policy, at (404) 657-9093 or via her e-mail at arussell@dch.ga.gov.

Sincerely,

Jerry Dubberly, PharmD, MBA
Chief, Medical Assistance Plans

cc: Heather Bond, Deputy Chief
Argartha Russell, Director, Medical Policy
Robert Finlayson, III, Inspector General
John Hankins, Audit Director, Office of Inspector General