

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

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EXECUTIVE SUMMARY

Kentucky did not pay some line items in accordance with its Medicaid National Correct Coding Initiative methodologies on claims that hospitals submitted. As a result, Kentucky made erroneous payments to providers totaling approximately \$84,000 (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. Kentucky Department of Medicaid Services (State agency) implemented the Medicaid-compatible NCCI payment methodologies (Medicaid NCCI) for claims filed on or after December 16, 2010, and did not report any incompatibilities between Kentucky'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 December 16, 2010, through December 31, 2012.

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 Kentucky, the State agency administers the Medicaid program. The State agency fully implemented the Medicaid NCCI in the Kentucky Medicaid Management Information System (KYMMIS), a computerized payment and information reporting system effective December 16, 2010. (CMS had given an extension to the October 1st deadline. The State agency implemented the first phase of the Medicaid NCCI on October 1, 2010.) 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 December 16, 2010, through December 31, 2012. Overall, the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI into KYMMIS on schedule. However, the Medicaid NCCI edits did not prevent erroneous payments. Of the 110 sampled line items, the State agency paid 102 in accordance with the Medicaid NCCI. For the remaining 8, the Medicaid NCCI edits did not prevent the payment for the component HCPCS code resulting in erroneous payments totaling \$1,853 (\$1,439 Federal Share).

Using our sample results, we estimated that the State agency made erroneous payments to providers totaling \$109,309 (\$83,569 Federal share).

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in KYMMIS 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.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund erroneous payments totaling \$83,569 to the Federal Government and
- ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the KYMMIS.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation to refund \$83,569 to the Federal Government but concurred with our second recommendation. The State agency acknowledged that four of the eight errors identified had NCCI edits applied incorrectly. For the remaining four errors, the State agency said that NCCI methodologies do not apply to these claims because, according to section 5.2 of the October 30, 2013, *Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies*, claims that are paid on a flat encounter/visit fee are not applicable to the NCCI methodologies. The State agency also said that the report did not provide the logic behind the claims sampling and how the overpayment amount was estimated, so it could not concur with the amount to be refunded.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The State agency did not provide sufficient documentation to support that the line items in question should have been paid based on a flat encounter/visit fee schedule rather than a fee schedule based on the HCPCS. In fact, the fiscal agent agreed that the

line items should not have been paid because of applicable NCCI edits. During the entrance conference on May 14, 2013, and during the exit conference on May 23, 2013, we explained to the State agency our sampling methodology. As specified in both the body of the report and Appendix B, the logic of selecting our sample was random, and the estimate was calculated using the Office of Inspector General, Office of Audit Services, statistical software. On the basis of our audit results, we continue to recommend that the State agency refund \$83,569 to the Federal Government.

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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 Kentucky Department of Medicaid Services (State agency) implemented the Medicaid-compatible NCCI payment methodologies (Medicaid NCCI) for claims filed on or after December 16, 2010, and did not report any incompatibilities between Kentucky'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 December 16, 2010, through December 31, 2012.

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/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 edits 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.

Kentucky's Implementation of Medicaid National Correct Coding Initiative Methodologies

In Kentucky, the State agency administers the Medicaid program. The State agency fully implemented the Medicaid NCCI in the Kentucky Medicaid Management Information System (KYMMIS), a computerized payment and information reporting system, effective December 16, 2010. The State agency contracted with its fiscal agent to implement the Medicaid NCCI. In a letter dated October 1, 2010,⁷ Kentucky's Medicaid agency notified providers that it was adopting the Medicaid NCCI to prevent the approval of payment for services that should not be billed together. The letter stated that the Medicaid NCCI edits would be applied to all claims submitted on or after October 1, 2010, excluding claims from certain providers who would be added later.⁸ Hospitals were not listed in the letter as excluded providers but provider types were identified.

HOW WE CONDUCTED THIS REVIEW

From CMS's Medicaid Statistical Information System (MSIS), we obtained approximately 5 million line items⁹ that the State agency paid to hospitals from December 16, 2010, through December 31, 2012, totaling approximately \$593 million for outpatient services. We did not review line items that did not include a HCPCS code; had a length of service of greater than 1 day; 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); matched to an active Medicaid NCCI edit that had an effective date after the HCPCS service date or before the Medicaid NCCI implementation date of December 16, 2010; or were submitted by a Critical Access Hospital (CAH). 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) were subsequently identified as a CAH line item and (2) contained an allowable modifier appropriately appended to one or both sides of a HCPCS code pair. From the

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 Kentucky Medicaid Provider Letter #A-81.

⁸ The State agency told us that it began applying Medicaid NCCI edits on claims from all providers by December 16, 2010. As such, we examined line items filed and processed by KYMMIS on or after that date.

⁹ A line item represented an individual service billed as part of a claim for a Medicaid beneficiary.

remaining 28,078 line items, totaling \$2,313,102 (\$1,784,873 estimated Federal share), we selected a random sample of 110 line items.

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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not pay some line items in accordance with its Medicaid NCCI methodologies on claims hospitals submitted from December 16, 2010, through December 31, 2012. Overall, the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI into KYMMIS on schedule. However, the Medicaid NCCI edits did not prevent erroneous payments. Of the 110 sampled line items, the State agency paid 102 in accordance with the Medicaid NCCI. For the remaining 8, the Medicaid NCCI edits did not prevent the payment for the component HCPCS code resulting in erroneous payments totaling \$1,853 (\$1,439 Federal share).

Using our sample results, we estimated that the State agency made erroneous payments to providers totaling \$109,309 (\$83,569 Federal share).

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in KYMMIS 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. Kentucky fully implemented the Medicaid NCCI edits into its MMIS and began editing claims against the Medicaid NCCI edit tables effective for claims filed on or after December 16, 2010. (CMS had given an extension to the October 1st deadline.) (See Appendix D 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. Of the 110 sampled line items, the State agency paid 102 in accordance with the

Medicaid NCCI. For the remaining 8, the Medicaid NCCI edits did not prevent the payment for the component HCPCS code resulting in erroneous payments totaling \$1,853 (\$1,439 Federal share).

The following table shows the erroneous line items containing the component HCPCS codes reported together with comprehensive HCPCS codes 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
74177 CT scan of abdomen and pelvis	96374 Injection of drug or substance into a vein for therapy	Yes	July 5, 2012
92980 Insert Intracoronary Stent	96372 Injection into tissue or muscle for therapy, diagnosis, or prevention	Yes	March 15, 2012
74150 CT scan abdomen	72192 CT scan pelvis	Yes	January 12, 2011
74150 CT scan abdomen	72192 CT scan pelvis	Yes	January 1, 2011
99218 Hospital observation care typically 30 minutes	99284 Emergency department visit, problem of high severity	Yes	December 9, 2010
87040 Bacterial blood culture	87070 Bacterial culture	Yes	March 1, 2012
88385 Evaluation molecular probes 51-250	88384 Evaluation molecular probes 11-50	Yes	October 4, 2011
74150 CT scan abdomen	72192 CT scan pelvis	Yes	January 6, 2011

The erroneous payments occurred because the fiscal agent did not ensure that Medicaid NCCI edits incorporated in KYMMIS 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.

ESTIMATE OF INCORRECT PAYMENTS

Using our sample results, we estimated that the State agency made erroneous payments to providers totaling \$109,309 (\$83,569 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund erroneous payments totaling \$83,569 to the Federal Government and
- ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the KYMMIS.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In written comments on our draft report, the State agency disagreed with our first recommendation to refund \$83,569 to the Federal Government but concurred with our second recommendation. The State agency acknowledged that four of the eight errors identified had NCCI edits applied incorrectly. For the remaining four errors, the State agency said that NCCI methodologies do not apply to these claims because, according to section 5.2 of the October 30, 2013, Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies, claims that are paid on a flat encounter/visit fee are not applicable to the NCCI methodologies. The State agency also said that the report did not provide the logic behind the claims sampling and how the overpayment amount was estimated, so it could not concur with the amount to be refunded.

Office of Inspector General Response

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The State agency did not provide sufficient documentation to support that the line items in question should have been paid based on a flat encounter/visit fee schedule rather than a fee schedule based on the HCPCS. In fact, the fiscal agent agreed that the line items should not have been paid because of applicable NCCI edits. During the entrance conference on May 14, 2013, and during the exit conference on May 23, 2013, we explained to the State agency our sampling methodology. As specified in both the body of the report and Appendix B, the logic of selecting our sample was random and the estimate was calculated using

the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software. On the basis of our audit results, we continue to recommend that the State agency refund \$83,569 to the Federal Government

The State agency comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 28,078 line items¹⁰ with payments totaling \$2,313,102 (\$1,784,873 estimated Federal share) for claims submitted performed from December 16, 2010, through December 31, 2012. We randomly selected 110 line items totaling \$12,117 for review. 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 May through June 2013 and performed our fieldwork at the State agency's office in Frankfort, Kentucky.

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 the State agency to understand how the Medicaid NCCI was implemented at hospitals within the State.
- We identified a sampling frame of 28,078 line items with payments totaling \$2,313,102 (\$1,784,873 estimated Federal share) by performing the following steps:
 - downloaded a database from CMS's MSIS that contained 5,261,297 line items with payments totaling \$592,710,650 and
 - did not review 5,233,219 line items totaling \$589,484,402.
- We randomly selected for review 110 line items, totaling \$12,117. For each line item, we:
 - used the State agency's MMIS to determine whether Medicaid paid for both HCPCS codes of the code pair,
 - determined whether the sampled items had been adjusted, and

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

- determined whether the State agency had applied the Medicaid NCCI edits.
- We conducted an accuracy test between the component code paid amounts in MSIS and KYMMIS.
- We conducted a completeness test¹¹ between MSIS claim counts and KYMMIS data for outpatient files for the third quarter of Federal fiscal year 2011.¹²
- To determine the Federal Share of the erroneously paid line items, we:
 - obtained from the State agency the eligibility records for the erroneous line items,
 - identified the Medicaid Fund Codes¹³ from the eligibility records,
 - obtained the quarterly FMAP rates for the Medicaid Fund Codes for the period of our review,
 - matched the FMAP rates to the sampled line item using the line item's service 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 the State agency.
- We estimated the unallowable Federal reimbursement paid in the sampling frame.

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.

¹¹ Testing for completeness means checking that both sets of records show all the accounts payable and state the amounts owed accurately.

¹² The third quarter of Federal fiscal year 2011 is from April 1, 2011, through June 30, 2011.

¹³ The Medicaid Fund Codes identifies the reason the beneficiary is eligible for the Medicaid program. The applicable FMAP is determined on the basis of a beneficiary's reason for Medicaid entitlement.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consists of outpatient line items payments that the State agency made to hospitals in Kentucky during December 16, 2010, through December 31, 2012.

SAMPLING FRAME

Using MSIS, the Region IV Advanced Audit Techniques Staff extracted a total of 5,261,297 outpatient line items totaling \$592,710,650 in payments to hospitals from December 16, 2010, through December 31, 2012. From this extraction, we removed 2,869,741 line items totaling \$353,773,440.

Line Items Removed From the Extraction

Removed Line Items	No. of Line Items	Payment Amount
Initial Extraction	5,261,297	\$592,710,650
Line items that did not include a HCPCS code	789,591	59,377,992
Line items for claims with a length of service greater than 1 day	2,698	888,407
Single line items that did not match to any other line items by provider, beneficiary, and date of service (i.e., line items with no code pair)	1,112,358	182,778,599
Line items matched to an active Medicaid NCCI edit that had an effective date after the HCPCS service date or prior to the Medicaid NCCI implementation date of December 16, 2010	834,034	101,628,662
Line items submitted by a CAH	131,060	9,099,780
Total Line Items Removed from Extraction	2,869,741	\$353,773,440
Total Remaining Line Items	2,391,556	\$238,937,210

After removing these line items, we identified a sampling frame of 28,078 line items with payments totaling \$2,313,102 (\$1,784,873 estimated Federal share) by performing the following steps:

- Using computer programming, we created a “coding pair data file”¹⁴ that compared the remaining 2,391,556 line items with other line items for the same (a) date of service, (b) provider, and (c) beneficiary. This data match identified 7,519,902 code pairs.

¹⁴ The coding pair data file contains two columns (comprehensive/component), and each row in the 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.

- We matched the 7,519,902 code pairs in our coding pair data file to the Medicaid NCCI edit tables that were effective from December 16, 2010,¹⁵ through December 31, 2012 (active NCCI code pairs). This data match identified 63,761 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)¹⁶ and the dollars associated with it.
- From the 63,761 line items, we removed (1) 28 line items identified as submitted by CAH and (2) 35,655 line items matched to a Medicaid NCCI edit with a modifier indicator of “1.”

SAMPLE UNIT

The sample unit was an individual Medicaid paid line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a total sample of 110 line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS Statistical Software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sampling frame from 1 through 28,078. After generating 110 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS Statistical Software to estimate the amount of incorrect payments.

¹⁵ We did not review line items with an adjudication date before the Medicaid NCCI implementation date of December 16, 2010.

¹⁶ The HCPCS code identified as not payable is in the component column of the edits tables. For example, a hospital should not report a CT scan abdomen (comprehensive column) and a CT scan pelvis (component column) together. In this case, the component code is included in the comprehensive code and should not be paid.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results: Total Amounts

Number of Lines Items	Value	Sample Size	Value of Sample	Number of Incorrect Line Items	Value of Incorrect Line Items
28,078	\$2,313,102	110	\$12,117	8	\$1,853

Sample Results: Federal Share Amounts

Number of Lines Items	Estimated Value (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Incorrect Line Items	Value of Incorrect Line Items (Federal Share)
28,078	\$ 1,784,873	110	\$9,136	8	\$1,439

Estimated Value of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount	Federal Share
Point estimate	\$472,987	\$367,237
Lower limit	109,309	83,569
Upper limit	836,664	650,906

APPENDIX D: 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 in order to promote correct coding and 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 Kentucky does not have a State regulation regarding the implementation of the Medicaid NCCI, it did implement the Medicaid NCCI by notifying providers through a provider letter dated October 1, 2010, that it had incorporated Medicaid NCCI edits. The letter stated that the Medicaid NCCI would be applied to all claims submitted on or after October 1, 2010, excluding claims from certain providers who would be added later. Hospitals were not listed in the letter as excluded providers. The State Medicaid agency told OIG auditors that it began applying Medicaid NCCI edits on claims from all providers by December 16, 2010.

APPENDIX E: STATE AGENCY COMMENTS



CABINET FOR HEALTH AND FAMILY SERVICES DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
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November 8, 2013

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Draft Audit Report A-04-13-06166 and Letter Dated October 9, 2013

Dear Ms. Pilcher:

The Kentucky Department for Medicaid Services (DMS) would like to take this opportunity to thank you and your staff for conducting an audit of Kentucky's implementation of the National Correct Coding Initiative (NCCI) Methodologies. DMS was pleased the report indicated that DMS had overall satisfied the Federal and State requirements by implementing the Medicaid NCCI methodologies into the claims payment system on schedule. The report also indicated that 102 of the 110 sampled lines items were paid in accordance with the Medicaid NCCI, leaving only 8 claim lines that were processed incorrectly. Using the Office of Inspector General (OIG) sampling and extrapolation methods, the report indicated that an estimated \$109,309 was incorrectly paid according to NCCI methodologies. While this error is small, DMS strives for 100% accuracy in all claims processing.

In accordance with your request in the cover letter, DMS is providing comments for each recommendation in the report:

Recommendation: "refund erroneous payments totaling \$83,569 to the Federal Government"

DMS Comments: DMS disagrees with this amount and further contends that only 4 of the 8 claims identified by HHS-OIG had NCCI edits applied incorrectly. According to the "Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies", dated October 30, 2013, Section 5.2, claims that are paid on a "flat encounter/visit fee" are not applicable to the Medicaid NCCI methodologies. Therefore, claims 2010349063625, 2011010048013, 2011011051863, and

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Lori S. Pilcher
November 8, 2013
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2211026005112 that were identified by HHS-OIG should not be included since these claims are flat fee claims. Furthermore, since only 4 claims appear to be in error and the report did not provide the logic behind the claims sampling and how the overpayment amount was "estimated", DMS cannot concur that the amount to be refunded is correct.

Corrective Action: DMS normal business process is to identify each specific claim that paid incorrectly. This process ensures that all incorrectly paid claims are identified for recovery and is more accurate than using the OIG estimates. Upon identification of the specific overpayments, the recovery process is started in accordance with state law. Federal funds are automatically returned upon recovery or within one year from identification, whichever occurs first.

Recommendation: "ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the KYMMIS."

DMS Comments: DMS concurs with this recommendation.

Corrective Action: DMS implemented change order 19226 to correct the NCCI issue within the claims payment system.

DMS is actively working to address the item identified in Audit Report A-04-13-06166. DMS looks forward to working with the OIG in the future. Should you have additional comments or questions regarding our corrective actions, please contact me at 502-564-5472.

Sincerely,



Veronica J. Cecil, Director
Division of Program Integrity
Department for Medicaid Services

Cc: Lawrence Kissner, Commissioner
Neville Wise, Deputy Commissioner
Jennifer Harp, Director Medicaid Systems Management