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INCONSISTENCIES IN STATE IMPLEMENTATION OF CORRECT CODING EDITS MAY ALLOW IMPROPER MEDICAID PAYMENTS

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EXECUTIVE SUMMARY: INCONSISTENCIES IN STATE IMPLEMENTATION OF CORRECT CODING EDITS MAY ALLOW IMPROPER MEDICAID PAYMENTS
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WHY WE DID THIS STUDY

Improper payments to healthcare providers constitute a significant vulnerability for Medicaid, costing an estimated $17.5 billion in fiscal year 2014. Automated claims processing safeguards called "edits" are critical program integrity tools that are available to State Medicaid agencies to prevent these improper payments. The Affordable Care Act required all States to implement the Medicaid National Correct Coding Initiative (NCCI) edits by October 1, 2010. The NCCI edits are designed to encourage providers to code correctly by automatically denying fee-for-service Medicaid payments for services that do not meet basic medical or billing standards.

HOW WE DID THIS STUDY

We used three data sources in our review. We surveyed all States about their progress and experiences implementing the NCCI edits. We asked all States to process a set of test claims to "spot check" their use of selected NCCI edits. We received their test claims results and survey responses in November 2014. We reviewed the cost savings estimates from the NCCI edits that States submitted to the Centers for Medicare & Medicaid Services (CMS) covering the period from January 2012 to August 2015.

WHAT WE FOUND

The effectiveness of the Medicaid NCCI edits was limited because some States had not fully implemented them and most did not use all of the edits correctly. States' inconsistent implementation and use of the edits may reduce their ability to promote correct coding by providers and prevent improper Medicaid payments. Additionally, States' lack of reporting of cost savings estimates, and the limitations of the estimates that were reported, inhibit CMS's ability to meaningfully estimate national NCCI cost savings. Despite these weaknesses, nearly all States reported that using the NCCI edits benefitted their Medicaid programs, and some voluntarily used the edits on claims paid under managed care.

WHAT WE RECOMMEND

We recommend that CMS (1) take appropriate action to ensure that States fully implement the NCCI edits, (2) provide technical assistance to States to ensure that they use the NCCI edits correctly, (3) issue guidance to States on how to estimate NCCI cost savings and take steps to ensure that States report as required, and (4) examine whether using the NCCI edits on claims paid under managed care is beneficial, and if so, take appropriate action. CMS concurred with all four recommendations.

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OBJECTIVES

1. To determine the extent to which States have implemented the required Medicaid National Correct Coding Initiative (NCCI) edits.
2. To determine the extent to which States used the NCCI edits consistent with NCCI program requirements.
3. To examine the extent to which States reported NCCI cost savings estimates to the Centers for Medicare & Medicaid Services (CMS), as required, and to assess the quality of the reported data.
4. To determine whether States voluntarily used the NCCI edits on Medicaid claims paid under managed care.

BACKGROUND

Edits are automated claims processing safeguards that are available to State Medicaid agencies to help ensure program integrity.[1] According to CMS, edits that are not implemented or working properly are a primary cause of improper payments.[2] Improper payments to healthcare providers constitute a significant vulnerability for Medicaid, costing a projected $17.5 billion in fiscal year 2014.[3]

The Affordable Care Act required all States to implement the Medicaid NCCI edits by October 1, 2010.[4] The NCCI edits automatically deny payment for services that do not meet basic medical or billing standards.[5] The NCCI edits are designed to encourage providers to use the correct medical billing codes that accurately reflect the services provided to a patient. These codes determine how much Medicaid pays to providers for each service. The NCCI edits have been an effective program integrity tool in the Medicare program. Since their implementation in Medicare in

[1] CMS, *Comprehensive Medicaid Integrity Plan Fiscal Years 2014-2018*, p. 15.

[2] Ibid.

[3] CMS, *Medicaid and CHIP 2014 Improper Payments Reports*, p. 3.

[4] The Patient Protection and Affordable Care Act, P.L. 111-148, § 6507 (March 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. 111-152 (March 30, 2010), collectively known as the Affordable Care Act.

[5] CMS, *National Correct Coding Initiative Policy Manual for Medicaid Services*, Introduction p. 3, January 1, 2014.

1996, the NCCI edits have saved over $7.5 billion dollars in program expenditures through 2013.[6]

Medicaid NCCI Edits

The NCCI edits are payment rules programmed into States' claims processing systems to automatically deny payment for ineligible and incorrectly coded services on Medicaid fee-for-service claims. For example, an NCCI edit would deny payment to a provider who bills Medicaid for more than one appendectomy on the same patient. When an NCCI edit denies payment for a service, providers may correct the coding for the service and rebill the Medicaid program, if appropriate. Ideally, over time, providers whose payments are denied because they are inconsistent with NCCI edits will code future claims correctly. The NCCI edits are based on, among other things, standard medical practice and coding conventions.[7] The NCCI edits apply only to services that are performed by the same provider, for the same beneficiary, on the same date of service.

There are two types of NCCI edits: (1) medically unlikely edits and (2) procedure-to-procedure edits. Each of the two edit types is used on claims from three types of services. Collectively, these comprise the six NCCI edit categories, as shown in Figure 1. In total, there are approximately 1.3 million NCCI edits, most of which are procedure-to-procedure edits. States may use the NCCI edits on claims paid under managed care, although it is not required.[8]

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[6] U.S. Department of Health and Human Services, *Report to Congress on the Implementation of the National Correct Coding Initiative in the Medicaid Program,* p. 3, March 1, 2011. Testimony of Shantanu Agrawal, CMS Deputy Administrator and Director on *CMS Efforts to Reduce Improper Payments in the Medicare Program* before the Committee on Oversight & Government Reform, Subcommittee on Energy Policy, Health Care & Entitlements, United States House of Representatives, May 20, 2014.

[7] CMS, State Medicaid Director Letter, *National Correct Coding Initiative*. SMDL #10-017, September 1, 2010.

[8] Managed care covers nearly three-quarters of Medicaid enrollees. CMS, *Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies*, p. 7, October 10, 2014. CMS, *Medicaid Managed Care Enrollment Report*: Summary Statistics as of July 1, 2013. Accessed at http://www.medicaid.gov on January 26, 2016.

Figure 1: Six Medicaid NCCI Edit Categories

Medically Unlikely Edits
1. Practitioner Medically Unlikely Edits
2. Outpatient Medically Unlikely Edits
3. Durable Medical Equipment Medically Unlikely Edits
Procedure-to-Procedure Edits
4. Practitioner Procedure-to-Procedure Edits
5. Outpatient Procedure-to-Procedure Edits
6. Durable Medical Equipment Procedure-to-Procedure Edits

Source: CMS, Medicaid NCCI Edit Design Manual, 2014.

Medically unlikely edits. Medically unlikely edits prevent payment for an inappropriate number of the same service for the same beneficiary on a single day. CMS defines the "medically unlikely value" for a service as the "maximum units of service reportable" under most circumstances, based on standard medical practice.[9] If a provider bills for more units of service than the medically unlikely value, payment for all units of service should be denied. According to CMS, denying payment for all units of service incentivizes providers to code correctly, because the provider must rebill for the correct number of services to receive any payment.[10] For example, because an individual has only one gallbladder, the medically unlikely value for a gallbladder removal surgery is one. If a provider bills for two gallbladder removal surgeries for a patient on the same day, the medically unlikely edit should deny payment for both surgeries. The provider may then rebill for a single gallbladder removal surgery, if appropriate.

Under certain circumstances, a provider may bill for multiple services provided to a beneficiary over a period of time (date span) without specifying the specific day that each service was provided. In these instances, the average units of service provided per day must not exceed the medically unlikely value for that service. For example, hospital patients may receive physical therapy treatment in a whirlpool once per day. However, hospitals may bill for more than one whirlpool treatment over the date span of the patient's stay as long as the average number of whirlpool treatments per day rounds to one or less.

[9] CMS, *National Correct Coding Initiative Policy Manual for Medicaid Services,* Chapter I p. I-6, January 1, 2014.

[10] CMS, *Fact Sheet: Updates on the Medicaid National Correct Coding Initiative Methodologies*, p. 4-5. Accessed at http://www.medicaid.gov on August 12, 2015.

Procedure-to-procedure edits. Procedure-to-procedure edits prevent payment for pairs of services that providers should not bill together on the same day (edit pair). If a provider bills for both services in a procedure-to-procedure edit pair for the same beneficiary on the same day, the edit specifies which service should be paid and should automatically deny payment for the other service. For example, a cardiac stress test includes multiple electrocardiograms, so a provider should not bill for an electrocardiogram in addition to the cardiac stress test. In this example, the procedure-to-procedure edit should allow payment for the cardiac stress test and deny payment for any separately billed electrocardiograms.

Under limited circumstances, providers may bill for both services in a procedure-to-procedure edit pair, though they would have to include one or more modifiers on the claim to receive payment. A modifier is a two-digit code that further describes the service(s) performed, and that may allow the claim to bypass an NCCI edit. For example, an NCCI edit would not allow providers to bill for two separate surgeries on one shoulder for a single beneficiary on the same day. However, if two surgeries were performed, one on each shoulder, providers may add modifiers to the claim that would allow it to bypass the NCCI edit.[11]

Medicaid NCCI Program Requirements

The Affordable Care Act required all States to implement the NCCI edits into their Medicaid claims processing systems.[12] Through technical guidance to States, CMS specifies how States must use the NCCI edits. NCCI program requirements include:

Correct order to use NCCI edits during claims processing. NCCI edits must be applied to Medicaid claims first, before applying any State-specific edits (State edits).[13] Although CMS allows States to use additional edits, applying the NCCI edits first can help promote coding consistency across Medicaid providers nationwide.

Correct quarterly edit file for use by States. CMS posts updated edit files for each of the six NCCI edit categories every quarter. The files are posted on the Medicaid Integrity Institute's secure Web site for States to download. States must download and use these files, rather than a similar

[11] Modifiers should only be used to bypass NCCI edits if documentation in the medical record supports the use of the modifier. CMS, *National Correct Coding Initiative Policy Manual for Medicaid Services,* Chapter I p. I-23, January 1, 2014.

[12] Affordable Care Act § 6507.

[13] States may use screening edits—such as those that check for Medicaid eligibility or missing information—before the NCCI edits. *Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies*, p. 16, October 10, 2014.

but less exhaustive "public-use" file that CMS publishes on its general Web site to inform providers of the NCCI edits.[14]

Correct timing for updating NCCI edits. CMS posts the updated edit files approximately 15 days prior to the start of each calendar quarter. States must use the updated set of edits beginning on the first day of the new calendar quarter.[15]

Cost savings estimates. CMS requires States to track estimated cost savings from the NCCI edits and report the estimates to CMS each quarter.[16] A CMS official indicated that CMS uses the States' reported cost savings data to estimate the national savings from the NCCI edits. CMS reports the estimated national savings to Congress as part of its annual Health Care Fraud and Abuse Control report, which describes Federal and State law enforcement and program integrity activities targeting health care fraud and abuse. Although CMS has provided States with a template for reporting cost estimates, it has not issued any guidance on how to estimate cost savings from the NCCI edits.

Related Work

This report extends the Office of Inspector General's (OIG's) examination of the role of program integrity tools, such as edits, in preventing improper payments and protecting the integrity of healthcare programs. For example, in 2003, OIG found that the Medicare NCCI edits were effective in preventing improper payments.[17] Further, in 2013, an OIG audit found that Georgia could have prevented $1.5 million in improper payments from November 1, 2010 to September 30, 2011, if it had used the Medicaid NCCI edits in a manner consistent with the program requirements.[18]

This report is the first national review of the Medicaid NCCI program.

METHODOLOGY

Data Collection

In November 2014, we surveyed all 50 States and the District of Columbia (hereinafter referred to as States) about their progress and experiences

[14] Ibid., p. 11.

[15] Ibid., pg. 12.

[16] Ibid., pg. 3.

[17] OIG, *Medicare's National Correct Coding Initiative*, OEI-03-02-00770, September 2003.

[18] OIG, *Georgia Did Not Pay Some Line Items on Medicaid Claims in Accordance With Its Medicaid National Correct Coding Initiative Methodologies*, A-04-12-06159, December 2013.

implementing and using the NCCI edits, and received survey responses from all States. We also asked each State to process 34 test claims through its Medicaid claims processing system to "spot check" its use of 34 selected NCCI edits during the period from November 1 to 15, 2014.[19] Although our test claims results are not projectable, this methodology allowed us to examine States' use of edits and provided indicators of whether States were using the edits correctly. All but one State submitted test claims results.[20] We followed up with States as needed to request clarification of their survey responses and test claims results. Finally, we requested from CMS the cost savings estimates that States submitted covering the period from January 2012 to August 2015.[21]

Data Analysis

States' implementation of the NCCI edits. To determine the extent to which States had implemented the edits in the six required NCCI edit categories, we analyzed States' survey responses and test claims results. We counted a State as having implemented or not implemented the edits from each NCCI edit category according to their responses on the survey, unless the test claims results conflicted with those responses. When we identified conflicts between survey responses and test claims results, we followed up with the State to clarify whether they had implemented the edits. Because all of the NCCI edits for a given edit category are contained in a single file, we considered a State to have implemented all edits in a category if it reported that it used the category's edit file and if the test claims results matched the States' report. We also analyzed States' responses regarding whether the edits had benefitted their Medicaid programs.

States' use of the NCCI edits. To determine the extent to which States used the NCCI edits correctly, we analyzed States' survey responses and test claims results. We analyzed States' survey responses to determine whether States reported practices that were consistent with selected NCCI

[19] See Appendix A for a detailed description of our test claims methodology, including why we chose the 34 selected NCCI edits. See Appendix B for a list of the test claims and expected outcomes.

[20] Utah officials reported that they tried to run our test claims through their claims processing system's test environment, but were unable to process them because of system limitations. Therefore, we excluded Utah from our test claims analysis.

[21] CMS required States to estimate and report NCCI cost savings beginning in 2011. However, States were allowed to deactivate any NCCI edits until April 2011 and according to CMS, many States had difficulty meeting the implementation deadline. Because of this, we examined States' cost savings reporting beginning with the first quarter of 2012. U.S. Department of Health and Human Services, *Report to Congress on the Implementation of the National Correct Coding Initiative in the Medicaid Program,* p.1, March 1, 2011.

program requirements on the use of medically unlikely edits (with and without date spans) and on the use of procedure-to-procedure edits (with and without modifiers). If a State reported one or more practices that were inconsistent with these requirements, we counted them among the States that did not always correctly use the applicable edits.

We also compared States' test claims results to the expected results, based on NCCI program requirements. We used the test claims to assess the implementation and use of 14 medically unlikely edits and 20 procedure to procedure edits. We coded each test claim result as correctly processed, incorrectly processed, or not tested.[22] Because the NCCI edits are implemented as part of a large edit category data file and then automated, a single incorrectly processed test claim may indicate that a State is misusing other, similar edits. Therefore, if a State incorrectly processed one or more medically unlikely or procedure-to-procedure test claims, we counted it among the States that did not always correctly use the applicable edits.

Order of edits and updating the edit files. We analyzed States' survey responses to determine whether they used NCCI edits prior to any State edits, as required, and to determine whether they updated the NCCI edit files correctly.

States' cost savings estimates. To determine the extent to which States reported NCCI cost savings estimates to CMS as required, we analyzed the cost savings reports that States submitted to CMS. To assess the cost savings estimates that were reported, we analyzed the States' survey responses describing how they estimated NCCI cost savings.

States' use of NCCI edits on claims paid under managed care. To examine whether States voluntarily used the NCCI edits on Medicaid claims paid under managed care, we analyzed States' survey responses. We asked those States that did use the NCCI edits on managed care claims why they decided to do so and whether they had experienced any challenges.

Limitations

We did not directly verify States' survey responses or test claims results. Instead, we relied on the documentation that they submitted and follow-up correspondence, as needed. Any changes that States may have made to their implementation or use of the NCCI edits subsequent to our November 2014 data collection are not reflected in this report.

[22] In some States, certain test claims could not test the intended NCCI edit for one of several reasons, such as claims for services that some State Medicaid agencies did not cover.

Our test claims results are limited in scope and completeness. We directly tested States' use of only 34 edits out of more than 1.3 million NCCI edits, because testing all NCCI edits was not feasible. Our test claims results cannot be projected to the population of NCCI edits. Additionally, we could not test all 34 edits in some States because of limitations in the States' claims processing system or other factors. Appendix A provides a detailed description of our test claims methodology, including reasons that some edits were not tested.

Standards

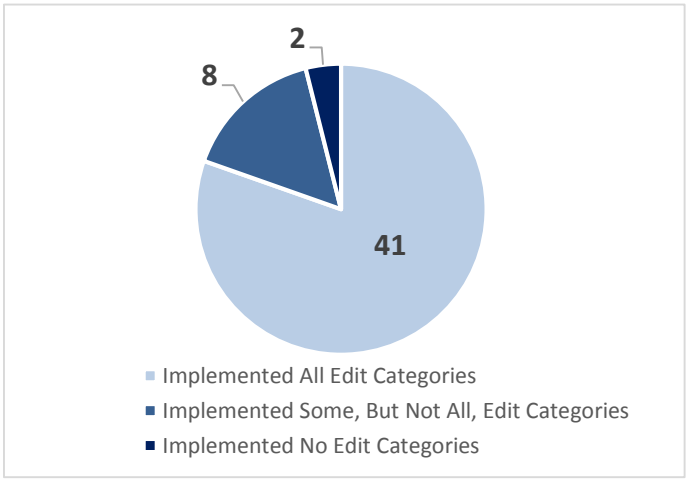
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Ten States had not implemented all required NCCI edits

More than 4 years after CMS required States to implement the NCCI edits, 10 States reported that they still had not implemented the edits from all 6 required NCCI edit categories. Of these, two States had not implemented any NCCI edits and eight States had implemented the edits from only some of the edit categories. Combined, these 10 States accounted for nearly 20 percent of national Medicaid spending in 2014.[23] For a full list of the 10 States and the edit categories that they did not implement, see Appendix C. Figure 2 shows the proportion of States that had implemented the edits from all, some, and none of the NCCI edit categories. The remaining 41 States reported that they had implemented the edits from all 6 NCCI edit categories, and the test claims from 40 of these States generally supported that they had implemented the edits.[24] Officials from 48 States reported that implementing the NCCI edits had benefitted their Medicaid programs by promoting correct coding by providers and/or preventing improper payments.

Figure 2: Implementation of Required NCCI Edit Categories Across State Medicaid Programs



Source: OIG analysis of States' survey responses and correspondence, 2015.

[23] In 2014, national Medicaid spending totaled $476 billion. Kaiser Family Foundation, *State Health Facts: Total Medicaid Spending.* Accessed at http://kff.org/medicaid/state-indicator/total-medicaid-spending/ on August 12, 2015.

[24] Utah officials reported that they tried to run our test claims through their claims processing system's test environment, but were unable to process them because of system limitations. Therefore, although Utah reported implementing the edits from all NCCI edit categories, it was unable to submit test claims results supporting implementation.

Two States had not correctly implemented any of the NCCI edits

Oklahoma had not implemented any of the NCCI edits into its Medicaid claims processing system. Oklahoma Medicaid officials reported that the Medicaid agency chose not to implement the edits because the State's claims processing system had some State edits that were "similar to the NCCI edits." However, States are required to implement the NCCI edits, even if they use State edits. Moreover, Oklahoma's test claims results showed that its State edits did not deny payment for all services that would have been denied by the NCCI edits.

Illinois had not implemented any of the NCCI edits in a manner consistent with NCCI program requirements. Although Illinois reported implementing the edits from four of the six NCCI edit categories, it did not implement any of the edits so as to automatically deny payments for improperly coded services without staff intervention.[25] Illinois officials reported that instead, they implemented the NCCI edits as "manual review" edits, which send each flagged claim to a staff member for review. For example, if a provider billed for two gallbladder removal surgeries for the same beneficiary, Illinois's claims processing system would flag that claim and send it to a staff member for manual review instead of automatically denying payment for the services. CMS officials indicated that Illinois's method of manually reviewing all claims flagged by NCCI edits did not constitute implementation of the edits. Because Illinois did not implement the NCCI edits as automated edits, we were unable to determine from their test claims results whether they would have correctly processed any of the test claims.

Eight States had implemented only some of the NCCI edits

Eight States had implemented edits from between two and five of the six NCCI edit categories.[26] Officials from the eight States reported various reasons for not implementing all edits; among them, system and resource constraints, competing priorities, and State policies. Of the eight States, North Carolina, New Mexico, and Ohio reported that they were in the process of implementing all the edits that they had not yet implemented.

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[25] CMS requires States to implement the NCCI edits to automatically deny payment for improperly coded services. CMS, *Center for Medicaid and CHIP Services Technical Guidance on State Implementation of the Medicaid National Correct Coding Initiative Methodologies*, p. 16-17, October 10, 2014.

[26] The eight States that reported they had implemented some, but not all six, of the required NCCI edit categories were Delaware, Louisiana, Maine, Missouri, New Jersey, New Mexico, North Carolina, and Ohio.

Louisiana reported that it was in the process of implementing the edits from one of the four edit categories that it had not yet implemented. The remaining four States did not indicate whether they were planning to implement their unimplemented edits. States that did not implement all required NCCI edits may have been improperly paying for Medicaid services that should have been denied by NCCI edits. For example, among the eight States that did not implement all required NCCI edits, the test claims results from six of the States showed that they would have paid for some services that should have been denied by NCCI edits that they did not implement.

Most States did not use all of the NCCI edits correctly

Of the 49 States that implemented the NCCI edits into their claims processing systems, 47 did not use all of the NCCI edits correctly. These States reported practices that were inconsistent with the NCCI program requirements and/or incorrectly processed one or more test claims.[27] Only two States – Indiana and Montana – reported following all of the NCCI program requirements that we reviewed and demonstrated correct use of the NCCI edits by correctly processing all applicable test claims. States that do not use all of the NCCI edits correctly may be improperly processing Medicaid claims—including paying for services that should be denied or denying payment for services that should be paid. Figure 3 describes the ways in which States incorrectly used the NCCI edits and the number of States in each category.

Figure 3: States' Incorrect Use of NCCI Edits

Description	Number of States
Did not use all medically unlikely edits correctly	35
Did not use all procedure-to-procedure edits correctly	29
Did not use the edits in the required order	18
Did not update the edits as required	13
Incorrectly used NCCI edits in at least one way	**47***

Source: OIG analysis of States' survey responses and test claims results, 2015.

*Column sums to more than 47 States because many States incorrectly used the NCCI edits in more than one way.

[27] See Appendix D for a full list of States' test claims results. See Appendix E for a full list of States' reporting on adherence to selected NCCI program requirements.

Incorrect use of medically unlikely edits

Thirty-five States did not use all of the medically unlikely edits in a manner consistent with NCCI program requirements. We found two main problems associated with States' use of medically unlikely edits: 1) not denying payment for all units of service on claims that trigger medically unlikely edits and 2) not correctly using medically unlikely edits on claims with date spans. The first problem arose when States did not program the medically unlikely edits in their claims processing systems to deny payment for all units of service, as required. Instead, these States programmed the medically unlikely edits to deny payment for only those units of service above the medically unlikely value. Some of these States reported that they were aware that their use of the medically unlikely edits did not align with NCCI program requirements, but reported that they used the edits in this way to avoid having providers rebill the Medicaid program for denied services. However, CMS believes that denying payment for all units of service incentivizes providers to correctly code future claims.[28]

The second problem arose when States did not program their claims processing systems to divide the units of service on the claim by the number of days in the date span before using the medically unlikely edits. Instead, many States denied payment for the service if the units of service exceeded the medically unlikely value without adjusting for the date span, possibly denying payment for eligible services.

Incorrect use of procedure-to-procedure edits

Twenty-nine States did not use all of the procedure-to-procedure edits in a manner consistent with NCCI program requirements. The main problem with States' use of procedure-to-procedure edits involved not following NCCI program requirements for using modifiers. This included paying for services that should be denied and denying payment for services that should be paid. State officials reported various reasons for misusing edits on claims with modifiers; among them, misunderstanding program guidance about when modifiers should allow claims to bypass NCCI edits and allowing some, but not all, modifiers to bypass NCCI edits.

Incorrect order of NCCI and State edits

Eighteen States did not use the NCCI edits on claims before using State edits, as required. When State edits are used before NCCI edits, they may "alter" the claim by denying payment for one or more services. These changes could cause claims to bypass NCCI edits when they should not.

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[28] CMS, *Fact Sheet: Updates on the Medicaid National Correct Coding Initiative Methodologies*, p. 4-5. Accessed at http://www.medicaid.gov on August 12, 2015.

Incorrect updating of NCCI edits

Thirteen States did not comply with NCCI program requirements for updating the NCCI edits. Five of the thirteen States reported that they did not download the Medicaid NCCI files from the Medicaid Integrity Institute Web site, as required. Instead, they downloaded and implemented the less comprehensive public NCCI edit files available for provider education on the Medicaid.gov Web site. Five other States reported that State officials did not download the NCCI edit files themselves, as required. Instead, claims processing contractors downloaded and implemented the NCCI edit files independently. According to CMS, only States should have access to the files on the Medicaid Integrity Institute Web site.

The remaining three States reported that they did not download and begin using the quarterly edit files on the first day of each calendar quarter, as required. Rhode Island reported that it did not implement any quarterly edit files, and gave no explanation. Maryland reported that it implemented the quarterly edit files, but took 4-6 months to implement them, and Missouri reported that it updated the edit files once per year. Officials from Maryland and Missouri attributed the delays to resource constraints.

Most States did not report NCCI cost savings to CMS as required, and the estimates that were reported had limited value

As of August 2015, 48 States had not reported NCCI cost savings estimates to CMS every quarter, as required. Of these States, 23 had reported cost savings estimates for some, but not all, quarters and 25 had never reported cost savings estimates. Some State officials explained that they had technical challenges or were unaware of the reporting requirement. Only one State – Mississippi – consistently reported their quarterly cost savings estimates to CMS. See Appendix F for a full list of States and the number of cost savings reports they submitted to CMS.

According to our review, States' reported cost savings estimates had limited value in terms of measuring actual cost savings from the NCCI edits. See Figure 5 for an illustration of these limitations. Estimating NCCI cost savings is difficult because the NCCI edits deny services before the final payment amount is determined.[29] Because of this, States estimate cost savings in different ways. Some States reported measuring

[29] Claims processing systems use an algorithm at the end of claims processing to determine how much a State Medicaid agency will pay for approved Medicaid services. This is referred to as the paid amount. NCCI edits deny services before the paid amount is calculated.

cost savings using the amount billed by the provider. This approach may overestimate cost savings because the amount that Medicaid pays for a service is typically less than the amount billed by the provider. Differences in estimation methodologies may be one reason that States reported a wide range of cost savings. For example, in the first two quarters of 2015, States' individual estimates of cost savings ranged from as little as $55,000 to as much as $127 million per quarter. States' lack of reporting, and the limitations of the cost savings estimates that were reported, inhibit CMS's ability to develop a meaningful estimate of national NCCI cost savings to report to Congress.

Figure 5: Summary of NCCI Cost Savings Data Limitations and Impact

NCCI Cost Savings Data Limitation	Impact
NCCI edits deny services before the payment amount is determined	Unable to determine cost savings from the denied service
States estimate cost savings in different ways	Cannot compare savings across States or calculate a national total
Some States measure savings using the amount billed by the provider	Savings may be overestimated, because billed amounts typically exceed what Medicaid pays

Source: OIG analysis of States' cost savings reports and survey responses, 2015.

Eleven States voluntarily used NCCI edits on claims paid under managed care

Although managed care covers nearly three-quarters of Medicaid enrollees, CMS generally does not require States to use NCCI edits on claims paid under managed care.[30] However, 11 States chose to use NCCI edits on managed care claims (see Appendix G for a list of these States). Among the 11 States, many reported that they decided to use the NCCI edits on managed care claims to ensure correct coding and to make their claims processing consistent across their Medicaid programs for both fee-for-service and managed care. Other States reported that they applied the NCCI edits to managed care claims to achieve cost savings. Officials from 9 of the 11 States reported no challenges to using the NCCI edits on

[30] CMS, Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-andSystems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf on July 16, 2015.

managed care claims. Officials from the other two States reported that the only challenge was getting their managed care organizations to implement the edits in a timely manner.

CONCLUSION AND RECOMMENDATIONS

According to CMS, edits that are not implemented or working properly are a primary cause of improper payments. When used correctly by States, NCCI edits automatically deny Medicaid payments for services that do not meet basic medical or billing standards. However, the effectiveness of the NCCI edits was limited because some States had not fully implemented the edits and most did not use all of the edits in a manner consistent with NCCI program requirements. Although some States reported that they unintentionally used the edits incorrectly, other States reported that they were aware that their use of the edits was not consistent with requirements, and gave a variety of reasons for this. States' inconsistent implementation and use of the edits may reduce their ability to promote correct coding by providers and prevent improper Medicaid payments. Further, States' lack of reporting of cost savings estimates, and the limitations of the estimates that were reported, inhibit CMS's ability to meaningfully estimate national NCCI cost savings.

To address these deficiencies, we recommend that CMS:

Take appropriate action to ensure that States fully implement the NCCI edits

CMS should take appropriate action to ensure that the 10 States that have not implemented edits from all six required edit categories do so. Appropriate actions may include corrective action plans, assessing penalties, and/or offering incentives to States that have not fully implemented the NCCI edits.

Provide technical assistance to States to ensure that they use the NCCI edits correctly

As part of its ongoing efforts, CMS should provide targeted technical assistance to ensure that States understand and follow NCCI program requirements concerning the issues identified in this report. CMS may wish to vary its assistance depending upon whether States are unintentionally misusing the edits or have chosen not to use the edits correctly.

Issue guidance to States on how to estimate NCCI cost savings and take steps to ensure that States report as required

In order to develop a meaningful estimate of national NCCI cost savings that it can include in its report to Congress, CMS should issue guidance to ensure that all States estimate cost savings in a consistent way. CMS should also take steps to ensure that States report those estimates as required.

Examine whether using the NCCI edits on claims paid under managed care is beneficial, and if so, take appropriate action

CMS should assess the impact of using the NCCI edits on claims paid under Medicaid managed care. This could include identifying the number of denied services, examining changes in provider billing, or if feasible, estimating cost savings. If CMS identifies an overall benefit, it should encourage States to use the NCCI edits on managed care claims and could share best practices from States on how to do so.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all four of our recommendations. In its comments, CMS stated that it would work with States to support their implementation of the NCCI edits and explore the use of incentives and other efforts to bring States into compliance. In addition, CMS stated that it would reevaluate its current technical assistance process and explore the barriers and challenges to State compliance with NCCI requirements. CMS noted that it recently consolidated the Medicare and Medicaid NCCI programs into a single program in order to increase the technical assistance that CMS can offer to the States. CMS further stated that it would work with States to develop and implement a methodology for estimating cost savings from the Medicaid NCCI similar to the methodology used to measure savings from the Medicare NCCI program. Finally, CMS stated that it will explore the current policies and processes for managed care claims processing and identify opportunities to improve the NCCI program with regard to managed care claims. The full text of CMS comments is provided in Appendix H.

APPENDIX A

Detailed Test Claims Methodology

We asked each State to process a set of 34 test claims through its Medicaid claims processing system to verify whether States were using 34 selected NCCI edits correctly. Fifty States submitted test claims results based on testing conducted during the period from November 1 – 15, 2014.[31]

We worked with CMS to develop the test claims methodology. CMS officials used their program knowledge to select the 34 edits. They chose edits related to services that they expected most State Medicaid programs to cover. The test claims were designed to test edits from all three categories of medically unlikely edits (with and without date spans), and all three categories of procedure-to-procedure edits (with and without modifiers). Services on 25 of the test claims should have been denied by an NCCI edit, and 9 claims included modifiers or date spans that should have allowed the services to be paid. Because these edits were purposively selected, our results cannot be projected to the population of NCCI edits. However, because the edits are implemented as part of a large edit category data file and then automated, a single incorrectly processed test claim may indicate that a State is misusing other, similar edits. Appendix B provides a list of the test claims and expected results.

For each test claim, we provided the States with basic information that mirrored actual Medicaid claims, such as the service type, procedure code, date of service, and units of service. States then ran the claims through their claims processing systems' test environments, which simulate what would have happened if they were real Medicaid claims. States submitted to OIG an electronic print-out of the results of the processed test claims. For example, if a service would have been denied by an NCCI edit, the test claim results included a message indicating which service was denied by an NCCI edit. If the test claim would have been paid, the test claim results showed the amount that the provider would have been paid for the service(s).

We reviewed States' test claims results and compared them to the expected results, according to NCCI program requirements. We then assigned each test claim result to one of the following categories:

- Correctly processed: the result matched the expected result according to NCCI program requirements (i.e., payment for the

[31] Utah officials reported that they tried to run our test claims through their claims processing system's test environment, but were unable to process them because of system limitations. Therefore, we excluded Utah from our test claims analysis.

correct service(s) were denied by an NCCI edit, or the correct service(s) were paid, as expected);

- Incorrectly processed: the result did not match the expected result according to NCCI program requirements (i.e., payment for a service was denied by an NCCI edit when it should not have been, or a service was paid when it should have been denied by an NCCI edit);
- Not tested: our test claim did not test the intended NCCI edit for one of several reasons. These reasons include: 1) the State paid for the tested service using a payment method to which the NCCI edits did not apply (e.g., many States pay for outpatient hospital services using revenue codes), 2) the service was not covered by the State's Medicaid program, or 3) a technical issue prevented testing whether the NCCI edit worked as intended.

We shared these initial test claims determinations and the expected results with each State. We gave States an opportunity to provide explanations for any incorrectly processed test claims. We evaluated States' responses, consulted with CMS as needed, and made adjustments to our determinations when appropriate.

After we finalized our test claim determinations, we calculated the number of test claims that each State processed correctly and incorrectly. We excluded test claims results that we coded as "not tested." We also calculated the number of States that incorrectly processed one or more test claims designed to test procedure-to-procedure edits or one or more test claims design to test medically unlikely edits. For these calculations, we excluded States that did not implement the associated edit categories. For a full list of States and their test claims results, see Appendix D.

APPENDIX B

Test Claims and Expected Results

Claims to Test Practitioner Procedure-to-Procedure Edits							
Test Claim	**Provider Type**	**Code[32]**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
1	Practitioner	58554		10/2/2014	10/2/2014	1	57106 should be denied with NCCI denial message
		57106		10/2/2014	10/2/2014	1	
2	Practitioner	57282		8/2/2014	8/2/2014	1	56810 should be denied with NCCI denial message
		56810		8/2/2014	8/2/2014	1	
3	Practitioner	72255		1/15/2014	1/15/2014	1	72255 should be denied with NCCI denial message
		72240		1/15/2014	1/15/2014	1	
4	Practitioner	24100		5/6/2013	5/6/2013	1	64417 should be denied with NCCI denial message
		64417	RT	5/6/2013	5/6/2013	1	
5	Practitioner	47420		7/7/2013	7/7/2013	1	47420 should be denied with NCCI denial message
		47600		7/7/2013	7/7/2013	1	
6	Practitioner	59400		1/15/2014	1/15/2014	1	Both codes should pay
		99213	25	1/15/2014	1/15/2014	1	
7	Practitioner	49550	59	1/15/2014	1/15/2014	1	Both codes should pay
		49505		1/15/2014	1/15/2014	1	
8	Practitioner	90723		9/23/2013	9/23/2013	1	90636 should be denied with NCCI denial message
		90636		9/23/2013	9/23/2013	1	

(Continued on page 22)

[32] The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT), copyright 2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

Claims to Test Outpatient Hospital Procedure-to-Procedure Edits							
Test Claim	**Provider Type**	**Code**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
9	Outpatient hospital	58660		10/2/2014	10/2/2014	1	49400 should be denied with NCCI denial message
		49400		10/2/2014	10/2/2014	1	
10	Outpatient hospital	57010		8/2/2014	8/2/2014	1	56810 should be denied with NCCI denial message
		56810		8/2/2014	8/2/2014	1	
11	Outpatient hospital	72265		1/15/2014	1/15/2014	1	72265 should be denied with NCCI denial message
		72255		1/15/2014	1/15/2014	1	
12	Outpatient hospital	24110		5/6/2013	5/6/2013	1	Both codes should pay
		64417	RT	5/6/2013	5/6/2013	1	
13	Outpatient hospital	45990		7/7/2013	7/7/2013	1	45990 should be denied with NCCI denial message
		45333		7/7/2013	7/7/2013	1	
14	Outpatient hospital	59510		1/15/2014	1/15/2014	1	Both codes should pay
		99214	25	1/15/2014	1/15/2014	1	
15	Outpatient hospital	49501		1/15/2014	1/15/2014	1	Both codes should pay
		49520	59	1/15/2014	1/15/2014	1	
16	Outpatient hospital	90748		9/23/2013	9/23/2013	1	90743 should be denied with NCCI denial message
		90743		9/23/2013	9/23/2013	1	
Claims to Test Durable Medical Equipment Procedure-to-Procedure Edits							
Test Claim	**Provider Type**	**Code**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
17	Durable Medical Equipment	L0454		9/3/2014	9/3/2014	1	L0455 should be denied with NCCI denial message
		L0455		9/3/2014	9/3/2014	1	
18	Durable Medical Equipment	L0472		1/15/2014	1/15/2014	1	L0468 should be denied with NCCI denial message
		L0468		1/15/2014	1/15/2014	1	
19	Durable Medical Equipment	L1846	LT	8/4/2013	8/4/2013	1	Both codes should pay
		L1845	RT	8/4/2013	8/4/2013	1	
20	Durable Medical Equipment	L5840	RT	11/15/2013	11/15/2013	1	L5826 should be denied with NCCI denial message
		L5826	RT	11/15/2013	11/15/2013	1	

(Continued on page 23)

Claims to Test Practitioner Medically Unlikely Edits							
Test Claim	**Provider Type**	**Code**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
21	Practitioner	A4566		10/2/2014	10/2/2014	3	All units of service (UOS) of A4566 should be denied with NCCI denial message
22	Practitioner	92570		10/2/2014	10/2/2014	2	All UOS of 92570 should be denied with NCCI denial message
23	Practitioner	31612		1/1/2014	1/1/2014	2	All UOS of 31612 should be denied with NCCI denial message
24	Practitioner	97012		1/15/2014	1/19/2014	7	All UOS of 97012 should pay
25	Practitioner	97026		1/15/2014	1/19/2014	8	All UOS of 97026 should be denied with NCCI denial message
26	Practitioner	92921		10/5/2013	10/5/2013	3	All UOS of 92921 should be denied with NCCI denial message
Claims to Test Outpatient Hospital Medically Unlikely Edits							
Test Claim	**Provider Type**	**Code**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
27	Outpatient hospital	A4290		10/2/2014	10/2/2014	3	All UOS of A4290 should be denied with NCCI denial message
28	Outpatient hospital	35045		10/2/2014	10/2/2014	3	All UOS of 35045 should be denied with NCCI denial message
29	Outpatient hospital	27193		1/15/2014	1/15/2014	2	All UOS of 27193 should be denied with NCCI denial message
30	Outpatient hospital	97022		1/15/2014	1/19/2014	7	All UOS of 97022 should pay
31	Outpatient hospital	97028		1/15/2014	1/19/2014	8	All UOS of 97028 should be denied with NCCI denial message
32	Outpatient hospital	92925		10/5/2013	10/5/2013	3	All UOS of 92925 should be denied with NCCI denial message
Claims to Test Durable Medical Equipment Medically Unlikely Edits							
Test Claim	**Provider Type**	**Code**	**Modifier**	**From Date**	**To Date**	**Units of Service**	**Expected Result**
33	Durable Medical Equipment	L5629		1/15/2014	1/15/2014	3	All UOS of L5629 should be denied with NCCI denial message
34	Durable Medical Equipment	A7014		9/4/2013	9/10/2013	9	All UOS of A7014 should pay

Source: CMS, 2014.

APPENDIX C

States That Reported Not Implementing Edits From All Six NCCI Edit Categories

State	Unimplemented Procedure-to-Procedure Edits?			Unimplemented Medically Unlikely Edits?			Number of Unimplemented Categories
	Practitioner	Outpatient	Durable Medical Equipment	Practitioner	Outpatient	Durable Medical Equipment	
1. Illinois	✓	✓	✓	✓	✓	✓	**6**
2. Oklahoma	✓	✓	✓	✓	✓	✓	**6**
3. Louisiana			✓	✓	✓	✓	**4**
4. New Jersey		✓	✓		✓	✓	**4**
5. Maine				✓	✓	✓	**3**
6. Missouri				✓	✓	✓	**3**
7. Ohio		✓			✓		**2**
8. Delaware			✓				**1**
9. North Carolina			✓				**1**
10. New Mexico			✓				**1**

Source: OIG analysis of States' survey responses and correspondence, 2015.

APPENDIX D

States' Test Claims Results

STATE	Number of test claims correctly processed	Number of test claims incorrectly processed	Number of edits not tested	Correctly processed all procedure-to-procedure test claims?	Correctly processed all test claims with modifiers?	Correctly processed all medically unlikely test claims?	Correctly processed all test claims with date spans?
AK	9	0	25	✓	✓	✓	✓
AL	23	3	8	✓	✓		
AR	15	1	18			✓	✓
AZ	14	7	13				✓
CA	15	1	18		✓	✓	✓
CO	19	0	15	✓	✓	✓	✓
CT	12	4	18	✓	✓		✓
DC	27	6	1			✓	N/A*
DE	28	5	1	✓	✓		
FL	21	2	11	✓	✓		
GA	25	1	8			✓	✓
HI	12	9	8				
IA	16	7	11	✓	✓		✓
ID	28	2	4			✓	✓
IN	28	0	6	✓	✓	✓	✓
KS	27	5	2				
KY	24	0	10	✓	✓	✓	✓
LA	15	8	11			N/A	N/A
MA	24	2	8	✓	✓		
MD	6	5	23			✓	✓
ME	17	9	8			N/A	N/A
MI	21	3	10		✓		
MN	28	1	5			✓	✓
MO	5	10	19			N/A	N/A
MS	25	4	5				
MT	27	0	7	✓	✓	✓	✓
NC	18	1	15	✓	✓	✓	✓
ND	19	0	15	✓	✓	✓	✓
NE	25	1	8	✓	✓		✓
NH	25	2	7	✓	✓		✓
NJ	7	12	15			✓	✓
NM	22	1	11	✓	✓	✓	✓
NV	17	8	9				✓
NY	21	3	10		✓		N/A
OH	20	1	13	✓	✓	✓	N/A
OR	14	2	18	✓	✓		✓
PA	6	7	21				✓
RI	8	4	22		✓		
SC	N/A	4	14		✓		✓
SD	33	0	1	✓	✓	✓	✓
TN	32	2	0				✓
TX	16	1	17	✓	✓		✓
UT	N/A	N/A	N/A	N/A	N/A	N/A	N/A
VA	23	0	11	✓	✓	✓	✓
VT	24	2	8	✓	✓		
WA	22	5	7	✓	✓		
WI	28	0	6	✓	✓	✓	✓
WV	24	2	8				✓
WY	22	4	8				✓

Source: OIG analysis of States' survey responses, test claims, and correspondence, 2015.

*For some States, certain test claims results categories were not applicable (N/A). For example, if they related to an edit category that the State did not implement.

APPENDIX E

State Reporting on Adherence to Selected NCCI Program Requirements

State	Reported correctly using procedure-to-procedure modifiers?	Reported correctly denying all units of service with medically unlikely edits?	Reported correctly using medically unlikely edits on claims with date spans?	Reported using the edits in the correct order?	Reported using the correct edit files when updating the edits?	Reported updating the edits as required?
AK		✓	✓		✓	✓
AL	✓	✓	✓	✓	✓	✓
AR	✓		✓		✓	✓
AZ	✓		✓	Unclear*		✓
CA	✓	N/A**	✓	✓	✓	✓
CO	✓		✓	✓	✓	✓
CT	✓			✓	✓	✓
DC	✓	✓	N/A	N/A		✓
DE		✓	✓	✓		✓
FL	✓			Unclear	✓	✓
GA	✓	✓	✓	✓	✓	✓
HI	✓	✓	✓	✓		✓
IA	✓	✓	✓		✓	✓
ID		✓	✓	N/A		✓
IN	✓	✓	✓	✓	✓	✓
KS	✓	✓	✓		✓	✓
KY	✓	✓	✓		✓	✓
LA		N/A	N/A			✓
MA	✓	✓	✓		✓	✓
MD		✓		Unclear	Unclear	
ME	✓	N/A	N/A	N/A		✓
MI	✓	✓	✓	✓	✓	✓
MN	✓		✓		✓	✓
MO	✓	N/A	N/A	✓	Unclear	
MS	✓	✓	✓		✓	✓
MT	✓	✓	✓	✓	✓	✓
NC		✓	✓	✓	✓	✓
ND	✓	✓			✓	✓
NE	✓	✓	✓	✓	✓	✓
NH	✓	✓	✓	✓	✓	✓
NJ		✓				✓
NM	✓	✓		✓	✓	✓
NV	✓	✓	✓	✓		✓
NY	✓	✓	N/A		✓	✓
OH	✓	✓	N/A	✓		✓
OR	✓	✓	✓	✓	✓	✓
PA			✓		✓	✓
RI	✓	✓	✓		Unclear	
SC	✓	✓		N/A	✓	✓
SD	✓	✓			✓	✓
TN	✓				✓	✓
TX	✓	✓	✓		✓	✓
UT	✓	✓			✓	✓
VA	✓		✓	N/A	✓	✓
VT		✓	✓	Unclear	✓	✓
WA	✓			Unclear	✓	✓
WI		✓	✓	✓	✓	✓
WV	✓	✓		✓	✓	✓
WY	✓		✓	✓	✓	✓

Source: OIG analysis of States' survey responses, 2015.

*For some States, we were unable to determine whether their reported process was consistent with NCCI program requirements.

**For some States, certain requirements were not applicable (N/A). For example, some States do not allow Medicaid claims to have date spans.

APPENDIX F

Number of Quarterly Cost Savings Estimates States Submitted to CMS, by Year

State	2012	2013	2014	2015*	Total
AK	0	0	0	0	0
AL	4	4	3	2	13
AR	0	0	0	0	0
AZ	4	4	3	2	13
CA	4	4	4	1	13
CO	0	3	3	1	7
CT	0	0	0	0	0
DC	0	0	0	0	0
DE	0	0	0	0	0
FL	0	0	0	0	0
GA	0	0	0	0	0
HI	4	4	3	2	13
IA	4	4	2	1	11
ID	0	0	4	1	5
IN	0	0	0	0	0
KS	3	3	3	2	11
KY	4	0	0	1	5
LA	1	4	4	2	11
MA	0	0	0	0	0
MD	0	0	0	0	0
ME	0	0	0	0	0
MI	0	0	0	0	0
MN	4	4	4	0	12
MO	0	0	0	0	0
MS	4	4	4	2	14
MT	4	4	2	0	10
NC	4	4	3	2	13
ND	4	3	0	0	7
NE	4	4	3	1	12
NH	0	0	0	0	0
NJ	0	0	0	0	0
NM	0	0	0	0	0
NV	1	4	4	1	10
NY	0	0	0	0	0
OH	0	0	0	0	0
OR	0	0	0	0	0
PA	4	4	3	2	13
RI	0	0	0	0	0
SC	0	0	0	0	0
SD	3	4	3	2	12
TN	0	0	0	0	0
TX	0	0	0	0	0
UT	4	2	0	1	7
VA	0	2	3	2	7
VT	4	4	2	0	10
WA	1	4	4	2	11
WI	0	0	0	0	0
WV	0	0	0	0	0
WY	4	3	0	0	7

Source: OIG analysis of quarterly cost savings estimates that States submitted to CMS covering the period of January 2012 to August, 2015.

*At the time of our data collection, States should have submitted two quarterly estimates in 2015.

APPENDIX G

States That Reported Using NCCI Edits on Managed Care Claims

State
Arizona
Florida
Iowa
Indiana
Kansas
Kentucky
Louisiana
Massachusetts
South Carolina
Tennessee
Vermont

Source: OIG analysis of States' survey responses, 2015.

APPENDIX H

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

MAR 29 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments" (OEI-09-14-00440)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS takes seriously its responsibility for the accountability, fiscal integrity, and funding of the Medicaid program.

CMS continuously works to reduce and prevent improper Medicaid payments. As one part of CMS' program integrity strategy, CMS works with states to implement automated claims processing safeguards called edits to prevent improper payments. The Affordable Care Act (ACA) required all states to implement the Medicaid National Correct Coding Initiative (NCCI), which utilizes edits by October 2010. These edits automatically deny payments for ineligible and incorrectly coded services for Medicaid fee-for-service claims and promotes national correct coding methodologies for Medicaid claims. CMS provides guidance and technical assistance to states on the implementation of the NCCI edits as needed and recently consolidated the Medicare and Medicaid NCCI programs into a single program in order to increase the technical assistance CMS can offer the states.. CMS will continue to work with states to make sure that the NCCI edits effectively benefit the Medicaid program.

CMS is strongly committed to program integrity efforts in Medicaid. In addition to the NCCI, CMS is increasing its role in Medicaid provider enrollment through additional guidance and outreach to states for compliance with ACA requirements, conducting collaborative audits through Audit Medicaid Integrity Contractors, which conduct post-payment reviews of Medicaid claims, revising the State Program Integrity reviews to include more in-depth analysis of state program integrity issues, and building stronger relationships with states to understand challenges and improve information sharing through our State Liaisons.

OIG's recommendations and CMS' responses are below:

OIG Recommendation:

The OIG recommends that CMS take appropriate action to ensure that states fully implement the NCCI edits.

/S/

CMS Response:

CMS concurs with this recommendation. CMS is committed to improving the Medicaid NCCI and will work with the states to support their implementation of the NCCI edits. In addition, CMS will explore the use of incentives and other efforts to bring states into compliance.

OIG Recommendation:

The OIG recommends that CMS provide technical assistance to states to ensure that they use the NCCI edits correctly.

CMS Response:

CMS concurs with this recommendation. As GAO notes, CMS currently provides technical assistance to the states, but CMS will re-evaluate current processes and further explore the barriers and challenges to state compliance.

OIG Recommendation:

The OIG recommends that CMS issue guidance to states on how to estimate NCCI cost savings and take steps to ensure that states report as required.

CMS Response:

CMS concurs with this recommendation. CMS will work with states to develop and implement a methodology for estimating cost savings similar to the Medicare NCCI.

OIG Recommendation:

The OIG recommends that CMS examine whether using the NCCI edits on claims paid under managed care is beneficial, and if so, take appropriate action.

CMS Response:

CMS concurs with this recommendation. Currently, implementation of NCCI edits is optional for use on claims paid by Managed Care Organizations. As states may use many different Managed Care program models, CMS will explore the current policies and processes for Managed Care claims processing and identify opportunities and best practices to improve the NCCI program for states.

ACKNOWLEDGMENTS

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

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Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of individuals served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and individuals. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.