Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

APPLYING THE NATIONAL CORRECT CODING INITIATIVE TO MEDICAID SERVICES

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ABSTRACT

The National Correct Coding Initiative (CCI) consists of automated edits used to evaluate Medicare claim submissions when a provider bills more than one service for the same beneficiary and same date of service. Although use of the CCI edits is mandatory in the Medicare program, State Medicaid agencies are not required to use these edits in processing their claims. Based on a 2003 survey of all State Medicaid agencies, we found that most States do not use the Medicare CCI edits. Only seven States use all or some of these coding edits. Our review of 2001 claims data available for 39 State Medicaid agencies found that these 39 States paid $54 million for services that would have been denied based on the CCI edits. Using these edits would promote correct coding by providers and reduce Medicaid expenditures for services that the edits would deny. Therefore, we recommend that the Centers for Medicare & Medicaid Services (CMS) encourage States to explore the use of Medicare CCI edits within their Medicaid programs. CMS concurred with our recommendation.

EXECUTIVE SUMMARY

OBJECTIVE

To determine (1) the extent to which State Medicaid agencies use the National Correct Coding Initiative (CCI) edits or similar edits and (2) the extent to which the Medicaid program paid for services that would have been denied if State Medicaid agencies implemented the CCI edits used by the Medicare program.

BACKGROUND

The Medicaid program was established in 1965 under Title XIX of the Social Security Act. Financed by a Federal-State partnership, the Medicaid program covers health services for approximately 40 million people including children, the aged, blind, or disabled, and people who are eligible to receive federally assisted income maintenance payments. Each State Medicaid agency administers its own program within Federal guidelines, and coverage policies may vary from State to State.

In January 1996, the Centers for Medicare & Medicaid Services (CMS) implemented the CCI in the Medicare program. This initiative was developed to promote correct coding of health care services by providers and to prevent Medicare payment for improperly coded services. The initiative consists of automated edits used to evaluate claim submissions when a provider bills more than one service for the same beneficiary and same date of service.

To determine if State Medicaid agencies use CCI edits or any similar edits, we conducted a mail survey of Medicaid agencies in all 50 States and the District of Columbia. Forty-nine of the fifty-one agencies responded to the survey.

To determine if State Medicaid agencies paid for services that would have been denied based on the CCI edits, we matched the fourth quarter 2001 CCI edits against CMS's Medicaid Statistical Information System claims data for the 39 States that had provided 2001 data at the time of our review. We then calculated the amount States paid for those services that the edits would have denied.

FINDINGS

Most State Medicaid agencies do not use the National Correct Coding Initiative edits. Only 7 of 49 State Medicaid agencies that responded to our 2003 survey reported that they use CCI edits in

processing their claims. These States do not all use CCI edits to the same extent. Two States reported using all CCI edits, three States use the edits only for particular types of services, and two States use only a small number of the edits.

Another eight States use a commercial edit package that includes edits to prevent payment for services by a provider on the same day for the same beneficiary. Commercial edit packages may be purchased by the States and modified to accommodate each State's coverage policies.

Thirty-two States do not use CCI edits or a commercial edit package but have other edits in place. States' edits include some that are comparable to CCI edits.

Two States reported that their systems do not include any edits to deny services performed by a provider on the same day for the same beneficiary. Another two States did not respond to our survey.

Thirty-nine State Medicaid agencies paid $54 million in 2001 for services that would have been denied based on the National Correct Coding Initiative edits. Thirty-nine States had provided 2001 Medicaid claims data at the time of our review. The 39 States paid $150 million in 2001 for 3.2 million services involving CCI code pairs that were performed by a provider on the same day for the same beneficiary. These States paid $57 million for services involving the second code in a CCI code pair, the services that CCI usually does not allow. Of this amount, $54 million (94 percent) was paid for services that would have been denied based on CCI edits. The remaining $3 million would have been appropriate according to the CCI edits since a valid CCI modifier was included with the code pair.

The amount paid for services that would have been denied based on the CCI edits varied widely by State. Payments in the 39 States ranged from $33,491 to over $9 million. States that reported using some or all of the CCI edits paid $4.1 million for services that would have been denied based on CCI edits. The States that use a commercial edit package paid $5 million for services that would have been denied based on CCI edits. States that use other edits paid $44.1 million for services that would have been denied based on CCI edits.

Nearly half of the $54 million in payments for services that CCI edits would have denied were made for code pairs in the Medicine category.[1] Services in this category include psychiatry, physical therapy, cardiovascular, and pulmonary services. Just 75 code pairs made up 75 percent of the payments for Medicine services that would have been denied based on the CCI edits.

RECOMMENDATION

Although most States have some edits in place to prevent inappropriate payments for services billed by a provider for the same beneficiary and same date of service, few States use CCI edits in processing their Medicaid claims. States are not required to use CCI edits; however, by using these edits, States could promote correct coding by providers and prevent payment for services that would be denied based on CCI edits.

At the time of our review, States could use their own local codes to identify services. However, under the Health Insurance Portability and Accountability Act, States are now required to use a uniform national coding system. A standardized coding system increases the potential for reducing inappropriate Medicaid payments through the use of CCI edits.

CMS should encourage States to explore the use of CCI edits. We recommend that CMS encourage States to explore the use of CCI edits within their Medicaid programs. We found that a small number of CCI edits in the Medicine category made up a large portion of Medicaid payments for services that CCI edits would have denied. Therefore, if implementing the entire CCI edit package is not practical, States may want to evaluate which CCI edits would produce the greatest reduction in payments in their Medicaid programs.

AGENCY COMMENTS

CMS concurred with our recommendation and stated that it will distribute our final report to each of its 10 regional offices so that the regional offices can work with States to explore the use of CCI edits. The complete text of CMS's comments can be found in Appendix C.

[1] The Medicine category is represented by codes 90000-99199 and 99500-99600 from the American Medical Association's *Current Procedural Terminology* manual. These include codes for non-invasive or minimally invasive services that are not considered open surgical procedures or evaluation and management services.

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INTRODUCTION

OBJECTIVE

To determine (1) the extent to which State Medicaid agencies use the National Correct Coding Initiative (CCI) edits or similar edits and (2) the extent to which the Medicaid program paid for services that would have been denied if State Medicaid agencies implemented the CCI edits used by the Medicare program.

BACKGROUND

The Medicaid program was established in 1965 under Title XIX of the Social Security Act. Financed by a Federal-State partnership, the Medicaid program covers health services for approximately 40 million people including children, the aged, blind, or disabled, and people who are eligible to receive federally assisted income maintenance payments. In fiscal year 2001, total Medicaid expenditures were $228 billion. Each State Medicaid agency administers its own program within Federal guidelines, and coverage policies may vary from State to State.

All State Medicaid agencies are required by law to implement pre-and post-payment claims analysis in their claims processing systems.[2] As part of pre-payment claims review, States use computerized or automated edits programmed into their claims processing systems. The edits are designed to prevent excessive payments by detecting inappropriate or unnecessary services. States are not required to use a single standardized edit package; each State may determine which edits to implement in its claims processing system.

While States' edits may differ, the Health Insurance Portability and Accountability Act requires that States use standardized code sets such as medical diagnostic codes and medical procedure codes for electronic claims transactions. This requirement went into effect on October 16, 2003. However, the Centers for Medicare & Medicaid Services (CMS) granted a 3-month extension for States to use local codes until December 31, 2003.

National Correct Coding Initiative

In January 1996, CMS implemented the CCI in the Medicare program. This initiative was developed to promote correct coding of health care services by providers and to prevent Medicare payment for improperly

[2] 42 U.S.C. § 1396a.

coded services. CMS developed these coding policies based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Although use of CCI edits is mandatory in the Medicare program, State Medicaid agencies are not currently required to use these edits in processing their claims. However, the edits would be applicable to the Medicaid program since they are based on general correct coding principles. The CCI edits are currently available to download from CMS's Web site.

The CCI edit files contain pairs of Healthcare Common Procedure Coding System (HCPCS) codes that generally should not be billed together by a provider for the same beneficiary and same date of service. One type of edit prevents payment for services that are components of a more comprehensive procedure. When comprehensive and component codes are billed together, Medicare pays for the comprehensive code but not the component code. For example, if an infusion procedure is performed, the placement of the catheter should not be billed separately because the placement of the catheter is considered a component of the infusion procedure. Therefore, according to the CCI edit, if both services are billed, only the comprehensive code for the infusion procedure would be paid. Another type of edit deals with mutually exclusive code pairs. These edits prevent payment for services that cannot reasonably be performed together. When mutually exclusive codes are billed together, Medicare generally pays for the least costly code.

METHODOLOGY

State Medicaid Agency Survey

To determine if State Medicaid agencies use CCI edits or any edits similar to CCI edits, we conducted a mail survey of the Medicaid agencies in all 50 States and the District of Columbia. For convenience, we will refer to the District of Columbia as a State throughout this report. We asked States whether or not they use the CCI edit package and, if applicable, when they implemented the CCI edits. We also asked States to describe any other types of automated pre-payment edits they have in place dealing with coding issues. We compared those States that reported using CCI edits to those States

that did not in terms of the dollars paid for services that CCI edits would have denied. We collected our data from May through July 2003. Forty-nine of the fifty-one States completed the survey, a response rate of 96 percent.

National Correct Coding Initiative Edits

We obtained CMS's data on CCI edits for the fourth quarter of 2001. The CCI edits are updated quarterly; however, the fourth quarter CCI edit update includes all prior additions and deletions of code pairs through the end of 2001. Since we reviewed 2001 Medicaid data, we removed all CCI edits with deletion dates prior to 2001 as well as CCI edits that were retroactively deleted during 2001. This left 123,316 CCI code pairs for our review.

The CCI edits are arranged so that the second code in a code pair is the service that is usually denied. In some instances, a modifier may be included that would allow both services in a CCI code pair to be paid. A modifier is a two-digit code that further describes the service performed. There are 35 modifiers that may be used to bypass CCI edits. Each CCI code pair has a modifier indicator that determines whether a modifier can be used.

Medicaid Statistical Information System

To determine if State Medicaid agencies paid for services that CCI edits would have denied, we matched the CCI edits against CMS's Medicaid Statistical Information System (MSIS) 2001 claims data for the 39 States that had provided data at the time we began our review. States submit Medicaid enrollment, payment, and utilization data to CMS for entry into the MSIS.

From the claims data file containing non-institutional services, we identified fee-for-service claims that involved CCI code pairs billed by a provider for the same beneficiary and same date of service. To determine if any of these services would have been denied based on CCI edits, we compared the date of service with the edit's effective date. This enabled us to determine whether the Medicare CCI edit was in place on the date the Medicaid services were performed.

We identified 3.2 million services involving active CCI code pairs billed by a provider for the same beneficiary and same date of service. Medicaid paid $150 million for these services in 2001. We then reviewed the data to determine if a modifier was allowed with the code pair and whether an appropriate modifier was included.

Based on our review, we calculated the total amount Medicaid paid for services that CCI edits would have denied. The total paid represents the amount Medicaid paid for the second service in a CCI code pair when:

1. The code pair did not allow a modifier.
2. The code pair allowed a modifier, but an appropriate modifier was not included.

Data Limitations

CCI edits are made up of national HCPCS codes. Many States used local codes at the time of our review; however, our review was limited to national HCPCS codes that were part of the CCI edits. All States did use some national HCPCS codes during our review, and it is these services that are included in our calculation of the amount Medicaid paid that CCI edits would have denied. Services billed with local codes are not captured by this review.

In addition, our data indicated that most State Medicaid agencies utilized the same modifiers as those used in the Medicare program. However, State Medicaid agencies also had the option to use their own unique modifiers. It is possible that States used local modifiers that would have allowed CCI edits to be bypassed; however, these modifiers would not have been recognized as valid for our review. Therefore, those services would be included in our calculation of the amount Medicaid paid that CCI edits would have denied.

For our analysis, we used the modifier indicator that was attached to the code pair in the fourth quarter 2001 CCI update. However, some modifier indicators changed during 2001, meaning that the code pair changed from allowing a modifier to not allowing a modifier or vice versa. Our calculations are based on the edits that were effective during 2001 and their associated modifier indicator from the fourth quarter of 2001.

Payments for some services may have been included in our calculations even if they involved adjusted payments. Adjustments may have occurred when two services in a CCI code pair were performed on the same day but billed to the Medicaid program separately. In this case, payment for both services may have been correct if payment of the second service was reduced to account for the payment of the service billed first. Only a manual review of claims history data could determine if the services were paid appropriately

due to such adjustments; we did not conduct a manual review of the data.

Finally, our calculations do not include any payments for services that CCI edits would have denied for the 12 States that had not submitted claims data to the MSIS at the time of our review.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Most State Medicaid agencies do not use the National Correct Coding Initiative edits.

Only 7 of 49 State Medicaid agencies that responded to our 2003 survey reported that they use CCI edits in processing their claims.[3] However, these States do not all use CCI edits to the same extent.

- Two States reported that they use all CCI edits.
- One State uses all CCI edits except those for anesthesia services.
- Two States use CCI edits related to surgical codes, but one uses these edits for post-payment rather than pre-payment review.
- Two States use just a small number of CCI edits. One State uses 149 CCI edits, and another uses 16.

States' Use of Commercial Edit Packages

Another eight States use a commercial edit package that includes edits to prevent payment for services performed by a provider on the same day for the same beneficiary. Commercial edit packages may be purchased by the States and modified to accommodate each State's coverage policies. While commercial edit packages may include edits for services covered by Medicaid that might not be captured by the CCI edits, they may not include all CCI edits currently used by Medicare.

States' Use of Other Edits

Thirty-two States do not use CCI edits or a commercial edit package but have other edits in place. States' edits include some that are comparable to CCI's comprehensive/component and mutually exclusive edits. A few States have edits that are based on CCI criteria.

Two States reported that their systems do not include any edits to deny services performed by a provider on the same day for the same beneficiary. A breakdown of the types of edits each State uses is presented in Appendix A.

Several States are planning to change their editing packages in the near future. Three States are planning to implement the entire CCI edit package. One State is adding more CCI edits, and one State is considering implementing some CCI edits. Another State is dropping

[3] The number of active edits in the CCI edit package at the time of our survey was approximately 200,000 edits.

the CCI edits that they used in their post-payment review and switching to a pre-payment commercial edit package.

Thirty-nine State Medicaid agencies paid $54 million in 2001 for services that would have been denied based on the National Correct Coding Initiative edits.

Thirty-nine States had provided 2001 Medicaid claims data at the time of our review. The 39 States paid $150 million in 2001 for 3.2 million services involving CCI code pairs that were performed by a provider on the same day for the same beneficiary. These States paid $57 million for services involving the second code in a CCI code pair, the services that CCI usually does not allow. Of this amount, $54 million (94 percent) was paid for services that would have been denied if CCI edits had been used in the Medicaid program. The remaining $3 million would have been appropriate according to the CCI edits since a valid CCI modifier was included with the code pair.

State Payments for Services CCI Edits Would Deny

The amount paid for services that would have been denied based on the CCI edits varied widely by State. Payments in the 39 States ranged from $33,491 to over $9 million. Twenty-four States each paid over $500,000 for services that would have been denied based on CCI edits. More than half of the $54 million in payments for services that would have been denied based on CCI edits were made by four States. These States did not use CCI edits. A list of States' payments for services that would have been denied based on CCI edits is included in Appendix A.

We found that even those States that reported using some or all CCI edits could reduce their payments for services involving CCI code pairs. For example, the two States that only use those CCI edits related to surgical procedures each paid over $500,000 for services that CCI edits would have denied. One State that reported using all of the CCI edits, still made payments for CCI code pairs. However, these payments may have been the result of the use of local modifiers, modifier indicator changes made during 2001, or adjustments made when the two services in a code pair were billed separately. Medicaid claims data were only available for five of the seven States that use CCI edits; therefore, we could only calculate the amount paid for services involving CCI code pairs for these States. These five States paid a total of $4.1 million for services that would have been denied based on CCI edits.

We found that the eight States that reported using a commercial edit package paid between $127,444 and $1.3 million for services that would have been denied based on CCI edits. These eight States paid a total of $5 million for services that would have been denied based on CCI edits.

We were able to calculate the amount paid by 24 of the 32 States that use other edits for services involving CCI code pairs, since claims data were only available for these States. The 24 States paid a total of $44.1 million for services that would have been denied based on CCI edits. These States paid an average of $1.8 million for services involving CCI code pairs performed by a provider on the same day for the same beneficiary.

Of the two States that do not have any edits to deny services performed by the same provider on the same day for the same beneficiary, one paid $228,835 for services involving the second code in a CCI code pair. This State was one of the smallest States in terms of total Medicaid expenditures. The other State reported that their new claims management system will incorporate the CCI edits. We did not have the claims data required to calculate payments made by this State.

Most Payments Made for Few Code Pairs

We found that Medicaid made payments for 17,797 of the 123,316 CCI code pairs. Nearly half of the $54 million in Medicaid payments were made for code pairs in the Medicine category.[4] Services in this category include psychiatry, physical therapy, cardiovascular, and pulmonary services. One code pair, relating to psychotherapy services, made up 12 percent of the Medicine payments that would have been denied based on CCI edits. In fact, just 75 code pairs made up 75 percent of the payments for Medicine services that would have been denied based on CCI edits. A list of the top 75 Medicine code pairs is presented in Appendix B. Payments for other categories of services such as Anesthesia, Surgery, Radiology, Pathology, and Evaluation and Management ranged from less than 1 percent to 10 percent of Medicaid payments for services CCI edits would have denied.

[4] The Medicine category is represented by codes 90000-99199 and 99500-99600 from the American Medical Association's *Current Procedural Terminology* manual. These include codes for non-invasive or minimally invasive services that are not considered open surgical procedures or evaluation and management services.

RECOMMENDATION

Although most States have some edits in place to prevent inappropriate payments for services billed by a provider for the same beneficiary and same date of service, few States use CCI edits in processing their Medicaid claims. States are not required to use CCI edits; however, by using these edits, States could promote correct coding by providers and prevent payment for services that would be denied based on CCI edits.

At the time of our review, States could use their own local codes to identify services. However, under the Health Insurance Portability and Accountability Act, States are now required to use a uniform national coding system. A standardized coding system increases the potential for reducing inappropriate Medicaid payments through the use of CCI edits.

CMS should encourage States to explore the use of CCI edits. We recommend that CMS encourage States to explore the use of CCI edits within their Medicaid programs. We found that a small number of CCI edits in the Medicine category made up a large portion of Medicaid payments for services that CCI edits would have denied. Therefore, if implementing the entire CCI edit package is not practical, States may want to evaluate which CCI edits would produce the greatest reduction in payments in their Medicaid programs.

Agency Comments

CMS concurred with our recommendation. If implementing the entire CCI edit package is not practical, CMS stated it will encourage States to evaluate which edits would produce the greatest reduction in payments in their Medicaid programs. CMS will also distribute our final report to each of its 10 regional offices so that the regional offices can work with States to carry out our recommendation. The complete text of CMS's comments can be found in Appendix C.

APPENDIX ~ A

State Medicaid Agencies' Use of Automated Edits and Payments for Services Involving CCI Code Pairs

State	Use CCI Edits	Extent of Use of CCI Edits	Use Commercial Edit Package	Use Other Edits	No CCI-Related Edits	Total Paid for Services Involving CCI Code Pairs	Total Paid for Services that Would Have Been Denied
AK			X			$555,793	$217,202
AL				X			
AR			X			$1,650,148	$562,969
AZ	X	Use all edits except for anesthesia				$261,845	$50,303
CA				X		$21,756,623	$7,226,709
CO				X		$3,170,824	$1,150,073
CT				X		$1,199,404	$534,222
DC					X	$573,044	$228,835
DE				X		$77,496	$33,491
FL				X		$4,681,198	$1,495,651
GA	X	Use all edits				$3,924,370	$935,291
HI							
IA				X		$2,971,321	$884,148
ID				X		$1,272,965	$392,153
IL				X		$935,748	$298,243
IN				X		$7,763,421	$2,821,799
KS				X		$1,446,315	$489,905
KY			X			$3,050,480	$1,127,206
LA				X		$3,933,439	$1,305,106
MA				X		$5,723,677	$2,104,502
MD				X		$336,867	$125,260
ME					X		
MI				X		$863,636	$304,762
MN				X			
MO				X		$10,415,460	$5,046,113
MS			X			$2,004,852	$531,470
MT	X	Use edits related to surgical codes				$1,544,359	$543,244
NC	X	Use 149 edits				$7,403,401	$2,035,207
ND	X	Use all edits					
NE				X		$2,183,193	$741,180
NH				X		$317,045	$122,696
NJ				X		$14,643,723	$6,116,975
NM				X			
NV				X			

APPENDIX - A

State	Use CCI Edits	Extent of Use of CCI Edits	Use Commercial Edit Package	Use Other Edits	No CCI-Related Edits	Total Paid for Services Involving CCI Code Pairs	Total Paid for Services that Would Have Been Denied[5]
NY[3]				X			
OH				X		$25,128,739	$9,180,167
OK			X			$978,519	$268,843
OR				X		$2,125,478	$528,994
PA				X		$1,575,242	$617,050
RI				X			
SC				X		$6,041,905	$2,054,331
SD				X			
TN						$232,678	$50,329
TX				X			
UT			X			$501,267	$127,444
VA			X			$3,288,616	$1,300,869
VT				X		$799,108	$317,790
WA	X	Use 16 edits					
WI			X			$2,132,297	$902,217
WV	X	Use edits related to surgical codes - Post-payment only				$1,824,796	$504,312
WY				X		$634,886	$230,803
Total	7[4]		8	32	2	$149,924,178	$53,507,864

Sources: 2003 OEI survey of State Medicaid agencies, CMS's 2001 MSIS fee-for-service claims data for 39 States.

[1] Since State had not submitted MSIS claims data at the time of our review, we were unable to calculate payments for services that CCI edits would have denied.

[2] This State reported using all CCI edits; however, we identified payments that should have been denied. This could be due to adjusted payments, modifier indicator changes during 2001, or the use of local modifiers by the State.

[3] State did not respond to survey.

[4] Five of the seven States that use CCI edits had the edits in place in 2001. North Carolina and North Dakota implemented the edits in 2002.

[5] This column was calculated based on payments for the second code in the CCI code pairs.

APPENDIX ~ B

Top 75 Services in the Medicine Category that CCI Edits Would Have Denied[1]

	Column 1 HCPCS Code and Description		Column 2 HCPCS Code and Description		Medicaid Payment for Column 2 HCPCS Code	Number of States with Code Pair
1	90847	Family psychotherapy w/patient	90804	Individual psychotherapy, office, 20-30 min	$2,761,811	20
2	96410	Chemotherapy infusion method	90780	IV infusion therapy, 1 hour	$936,033	35
3	95903	Motor nerve conduction test, with F-wave	95900	Motor nerve conduction test, without F-wave	$917,724	39
4	97530	Therapeutic activities	97116	Gait training therapy	$711,771	33
5	90853	Group psychotherapy	90804	Individual psychotherapy, office, 20-30 min	$698,342	26
6	97140	Manual therapy	97530	Therapeutic activities	$551,683	32
7	90806	Individual psychotherapy, off, 45-50 min	90862	Medication management	$549,513	30
8	90853	Group psychotherapy	90862	Medication management	$543,913	27
9	90853	Group psychotherapy	90806	Individual psychotherapy, off, 45-50 min	$516,779	26
10	90853	Group psychotherapy	90816	Indiv psychotherapy, hosp, 20-30 min	$471,111	18
11	96412	Chemotherapy, infusion method add-on	90780	IV infusion therapy, 1 hour	$470,084	34
12	90857	Interactive group psychotherapy	90853	Group psychotherapy	$353,131	6
13	93505	Biopsy of heart lining	93501	Right heart catheterization	$351,673	30
14	90847	Family psychotherapy w/patient	90806	Individual psychotherapy, off, 45-50 min	$329,337	27
15	90853	Group psychotherapy	90801	Psychiatric diagnostic interview	$317,970	24
16	92980	Insert intracoronary stent	92982	Coronary artery dilation	$297,530	30
17	90853	Group psychotherapy	90847	Family psychotherapy w/patient	$280,970	18
18	90804	Indiv psychotherapy, office, 20-30 min	90862	Medication management	$268,097	28
19	94060	Evaluation of wheezing	94375	Respiratory flow volume loop	$261,868	36
20	96530	Pump refilling, maintenance	96410	Chemotherapy infusion method	$258,976	33
21	97530	Therapeutic activities	97535	Self-care management training	$240,296	28
22	99233	Subsequent hospital care	94657	Continued ventilator management	$202,131	32
23	92980	Insert intracoronary stent	93556	Imaging, cardiac catheterization	$200,649	39
24	94010	Breathing capacity test	94375	Respiratory flow volume loop	$190,105	34
25	96530	Pump refilling, maintenance	96412	Chemotherapy, infusion method add-on	$185,783	32
26	90847	Family psychotherapy w/patient	90801	Psychiatric diagnostic interview	$181,727	22
27	90806	Individual psychotherapy, off, 45-50 min	90801	Psychiatric diagnostic interview	$180,289	29
28	93005	Electrocardiogram (ECG), tracing	93041	Rhythm ECG, tracing	$179,786	25
29	92508	Group speech/hearing therapy	92507	Individual speech/hearing therapy	$172,816	15
30	94060	Evaluation of wheezing	94664	Aerosol or vapor inhalations	$169,610	36
31	96410	Chemotherapy infusion method	90781	IV infusion, additional hour	$157,546	32
32	90847	Family psychotherapy w/patient	90862	Medication management	$150,891	23
33	97150	Group therapeutic procedures	97110	Therapeutic exercises	$150,315	21
34	90847	Family psychotherapy w/patient	90816	Individual psychotherapy, hosp, 20-30 min	$140,729	11
35	92980	Insert intracoronary stent	93555	Imaging, cardiac catheterization	$139,440	38
36	97110	Therapeutic exercises	97002	Physical therapy reevaluation	$136,902	31
37	97150	Group therapeutic procedures	97530	Therapeutic activities	$134,226	19
38	90853	Group psychotherapy	90818	Individual psychotherapy, hosp, 45-50 min	$129,144	17
39	97012	Mechanical traction therapy	97140	Manual therapy	$129,029	28

[1] We considered a code pair to be in the Medicine category if the Column 2 code, the code that would be denied by CCI, was in the Medicine category. The Medicine category includes codes in the range 90000-99199 and 99500-99600 from the American Medical Association's *Current Procedural Terminology* manual.

APPENDIX ~ B

	Column 1 HCPCS Code and Description		Column 2 HCPCS Code and Description		Medicaid Payments for Column 2 HCPCS Code	Number of States with Code Pair
40	93000	Electrocardiogram (ECG), complete	93040	Rhythm ECG with report	$120,979	31
41	99232	Subsequent hospital care	94657	Continued ventilator management	$116,664	31
42	97113	Aquatic therapy/exercises	97110	Therapeutic exercises	$116,346	28
43	94060	Evaluation of wheezing	94640	Airway inhalation treatment	$115,214	35
44	90804	Indiv psychotherapy, office, 20-30 min	90801	Psychiatric diagnostic interview	$111,257	22
45	96115	Neurobehavioral status exam	96111	Developmental test, extended	$103,773	11
46	92506	Speech/hearing evaluation	92507	Individual speech/hearing therapy	$103,034	26
47	94060	Evaluation of wheezing	94010	Breathing capacity test	$97,651	34
48	93350	Echo transthoracic	93307	Echo exam of heart	$95,315	35
49	90925	ESRD-related services, day	90935	Hemodialysis, one evaluation	$92,134	26
50	97530	Therapeutic activities	97113	Aquatic therapy/exercises	$90,237	21
51	93017	Cardiovascular stress test	93005	Electrocardiogram, tracing	$88,200	21
52	90801	Psychiatric diagnostic interview	90862	Medication management	$87,895	26
53	96412	Chemotherapy, infusion method add-on	90781	IV infusion, additional hour	$87,706	31
54	90846	Family psychotherapy w/o patient	90806	Individual psychotherapy, off, 45-50 min	$81,090	15
55	94640	Airway inhalation treatment	94664	Aerosol or vapor inhalations	$80,540	32
56	97140	Manual therapy	97124	Massage therapy	$79,644	30
57	92982	Coronary artery dilation	93556	Imaging, cardiac catheterization	$79,064	38
58	93621	Electrophysiology evaluation	93620	Electrophysiology evaluation	$78,970	16
59	93641	Electrophysiology evaluation	93620	Electrophysiology evaluation	$78,909	28
60	97504	Orthotic training	97110	Therapeutic exercises	$76,668	26
61	96530	Pump refilling, maintenance	96408	Chemotherapy, push technique	$67,750	31
62	93303	Echo transthoracic	93307	Echo exam of heart	$67,234	25
63	90806	Individual psychotherapy, off, 45-50 min	90805	Indiv psychotherapy, off, 20-30 min w/e&m	$65,677	22
64	98941	Chiropractic manipulation	97140	Manual therapy	$65,446	7
65	93010	Electrocardiogram (ECG) report	93042	Rhythm ECG, report	$63,228	35
66	90816	Indiv psychotherapy, hosp, 20-30 min	90801	Psychiatric diagnostic interview	$62,695	19
67	90853	Group psychotherapy	90817	Indiv psychotherapy, hosp, 20-30, w/e&m	$61,398	12
68	97035	Ultrasound therapy	97022	Whirlpool therapy	$59,850	26
69	90847	Family psychotherapy w/patient	90812	Interact indiv psychotherapy, off, 45-50 min	$55,142	9
70	95810	Polysomnography, 4 or more	95811	Polysomnography w/cpap	$53,515	21
71	99211	Office/outpatient visit, established patient	90862	Medication management	$51,028	18
72	90853	Group psychotherapy	90805	Indiv psychotherapy, off, 20-30 min w/e&m	$50,831	21
73	76856	Ultrasound exam, pelvic, complete	93975	Vascular study	$50,793	27
74	90925	ESRD-related services, day	90937	Hemodialysis, repeated evaluation	$50,342	11
75	92553	Audiometry, air & bone	92555	Speech threshold audiometry	$50,087	37
					$17,876,036	

APPENDIX ~ C

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

Administrator
Washington, DC 20201

DATE: AUG 19 2004

TO: George F. Grob
Acting Deputy Inspector General for Evaluation and Inspections

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *"Applying the National Correct Coding Initiative to Medicaid Services,"* (OEI-03-02-00790)

Thank you for the opportunity to review and comment on the above-referenced draft report. OIG reviewed the applicability of a series of edits developed by Medicare, which have proven effective in identifying areas of abuse due to up-coding or other inappropriate usage of various codes within Title XVIII. OIG thought there would be value in applying the same coding edits to Medicaid claims on a sample basis to see whether, and to what extent, use of such edits would prove similarly useful in Title XIX. OIG concluded that the Correct Coding Initiative (CCI) might have considerable merit, even on a limited basis, since a small number of edits yielded large results.

The Centers for Medicare & Medicaid Services (CMS) applauds OIG's efforts in this regard. We believe there would be value in encouraging states to look seriously into OIG's recommendation and, where appropriate, incorporate these or similar edits into their mechanized claims processing systems. CMS will not mandate such edits at this time due to the variety of systems and approaches in state Medicaid Management Information Systems. However, we will ask our regional office systems staff to work closely with state systems staff to glean whatever value can be gained from the OIG's very useful analysis.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. Our response to the OIG audit recommendation follows.

OIG Recommendation

The CMS should encourage states to explore the use of CCI edits within their Medicaid programs. OIG found that a small number of CCI edits in the Medicine category made up a large portion of Medicaid payments for services that CCI edits would have denied. Therefore, if implementing the entire CCI edit package is not practical, states may want to evaluate which CCI edits would produce the greatest reduction in payments in their Medicaid programs.

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CMS Response

We concur. Because a small number of edits in the Medicine category made up a large portion of Medicaid payments for services that CCI edits would have denied, if implementing the entire CCI edit package is not practical, we will encourage states to evaluate which edits would produce the greatest reduction in payments in their Medicaid programs. Once the OIG's report is published in final, we will distribute copies to each of our 10 regional offices in order for them to work with the states to carry out OIG's recommendation.

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