Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IDAHO CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING PROVIDER-PREVENTABLE CONDITIONS

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Office of Inspector General

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EXECUTIVE SUMMARY

Idaho claimed $4.3 million in Federal Medicaid reimbursement over 2 years for inpatient hospital services related to certain provider-preventable conditions, some portion of which was unallowable.

WHY WE DID THIS REVIEW

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs. We conducted this review to determine whether Idaho was in compliance with the new regulations for inpatient hospital services. This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

Our objective was to determine whether the Idaho Department of Health and Welfare (State agency) claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

BACKGROUND

PPCs can be identified on inpatient hospital claims through certain diagnosis codes. Diagnosis codes are used to identify a patient's health conditions. PPCs include two categories of conditions: health-care-acquired conditions and other PPCs. Health-care-acquired conditions are conditions that (1) are considered to have a high cost or occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented. These conditions include, among others, surgical site infections and foreign objects retained after surgery. Other PPCs are certain conditions identified in a State plan and must include, at a minimum, three specific conditions identified in Federal regulations.

For each diagnosis code on a claim, an inpatient hospital reports one of four present-on-admission indicator codes (POA codes). The POA code indicates that the condition was either present or not present when the patient was admitted as an inpatient to the hospital, the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or the provider could not clinically determine whether the condition was present on admission.

The Patient Protection and Affordable Care Act (ACA) and Federal regulations prohibit Federal payments for health-care-acquired conditions. Federal regulations implementing the ACA authorize States to identify other PPCs for which Medicaid payments will also be prohibited. Both Federal regulations and the Idaho State plan require that payment for a claim be reduced by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated.

For claims with dates of service on or after September 1, 2012, the Idaho State plan prohibits payment for the portion of a claim attributable to a PPC. Payment is prohibited for claims for

inpatient hospital services that contain health-care-acquired conditions for which a POA code (1) indicates the condition was not present at the time of inpatient admission, (2) indicates the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) is missing. Payment is also prohibited for claims that contain other PPCs.

From July 1, 2012, through June 30, 2014 (audit period), the State agency claimed $613.7 million ($436.8 million Federal share) for inpatient hospital services.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. For our audit period, we identified 4,766 claim lines totaling $6,080,902 ($4,333,025 Federal share) that contained PPCs and (1) a POA code indicating that the condition was not present on admission, (2) a POA code indicating that the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) no POA code. The PPCs we identified were health-care-acquired conditions. We did not identify other PPCs in the claim lines we reviewed.

Although Federal regulations prohibited the State agency from paying for services related to PPCs, and under its State plan, the State agency would no longer pay for inpatient hospital services related to PPCs as of September 1, 2012, the State agency did not have internal controls to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $6,080,902 ($4,333,025 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by the Centers for Medicare & Medicaid Services (CMS) and the State agency.

During our audit, the State agency was in the process of developing and revising edits within its Medicaid Management Information System (MMIS) to identify and deny payment of claims that contained PPCs. State agency officials indicated that the edits were fully implemented as of August 2015. Because the edits were not fully implemented until after our audit period, we did not determine whether they were effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

WHAT WE RECOMMEND

We recommend that the State agency:

- work with CMS to determine what portion of the $4,333,025 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount,

- review all paid claims after our audit period for inpatient hospital services to determine whether payments should be adjusted for any claims that contained PPCs and refund to the Federal Government its share of any unallowable amounts, and

- ensure that its MMIS edits are fully implemented and effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs.[1] We conducted this review to determine whether Idaho was in compliance with the new regulations for inpatient hospital services. This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

OBJECTIVE

Our objective was to determine whether the Idaho Department of Health and Welfare (State agency) claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Federal Government pays its share of a State's medical assistance expenditures under Medicaid according to the Federal medical assistance percentage (FMAP). During our audit period, Idaho's FMAP ranged from 70.23 percent to 80.15 percent.

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims through certain diagnosis codes.[2] Diagnosis codes are used to identify a patient's health conditions.

PPCs include two categories of conditions: health-care-acquired conditions and other PPCs.

- **Health-care-acquired conditions** are conditions acquired in a health care setting that (1) are considered to have a high cost or occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented (the

[1] The Centers for Medicare & Medicaid Services (CMS) delayed its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies.

[2] Diagnosis codes are listed in the *International Classification of Diseases* (ICD), which is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. CMS and the National Center for Health Statistics provide guidelines for reporting ICD diagnosis codes. During our audit period, the applicable version of the ICD was the 9th Revision, Clinical Modification (ICD-9-CM).

Social Security Act § 1886(d)(4)(D)(iv)). These conditions include, among others, surgical site infections and foreign objects retained after surgery; they are identified as Medicare hospital-acquired conditions, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients (42 CFR § 447.26(b)). Each State agency must identify for nonpayment the conditions on the list of Medicare hospital-acquired conditions and is required to comply with subsequent updates or revisions to the list (76 Fed. Reg. 32816, 32820 (June 6, 2011)).

- **Other PPCs** are certain conditions identified in a State plan and must include, at a minimum, the following three specific conditions identified in Federal regulations: a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, and a surgical or other invasive procedure performed on the wrong patient (42 CFR § 447.26(b)).

Diagnosis Codes and Present-on-Admission Codes

An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes.[3] For each diagnosis code on a claim, inpatient hospitals report one of four present-on-admission indicator codes (POA codes), described in the table below.

Table: The Four Present-on-Admission Indicator Codes

POA Code	Definition
Y	Condition was present at the time of inpatient admission
N	Condition was not present at the time of inpatient admission
U	Documentation is insufficient to determine whether condition was present on admission
W	Provider is unable to clinically determine whether condition was present on admission

Prohibition of Payment for Provider-Preventable Conditions

The Patient Protection and Affordable Care Act (ACA)[4] and Federal regulations prohibit Federal payments for health-care-acquired conditions. Federal regulations authorize States to identify other PPCs for which Medicaid payments will also be prohibited.[5] Both Federal regulations and the Idaho State plan require that payment for a claim be reduced by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated.

[3] The principal diagnosis is the condition established after study to be chiefly responsible for the admission, and secondary diagnosis codes describe any additional conditions that coexist at the time of service.

[4] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

[5] Before enactment of the ACA and its implementing Federal regulations, PPCs (i.e., health-care-acquired conditions and other PPCs) were referred to as hospital-acquired conditions and adverse events, respectively.

For claims with dates of service on or after September 1, 2012, the Idaho State plan prohibits payment for the portion of a claim attributable to a PPC. Payment is prohibited for claims for inpatient hospital services that contain health-care-acquired conditions for which a POA code (1) indicates the condition was not present at the time of inpatient admission, (2) indicates the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) is missing. Payments are not reduced for conditions that were present before admission or that the provider was clinically unable to determine were present before admission. The Idaho State plan also prohibits payment for claims that contain procedure code modifiers indicating the claims contain other PPCs.[6]

Idaho Medicaid Claims Processing and Identification of Claims With Provider-Preventable Conditions

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment. The expenditures related to the claims are reported on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement.

In January 2014, the State agency implemented edits within its MMIS to identify claims that contained PPCs. The State agency revised the edits in February 2015 to deny payment of claims that contained PPCs. The edits were not fully implemented until August 2015, after our audit period.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through June 30, 2014 (audit period), the State agency claimed $613,692,372 ($436,818,970 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify claim lines[7] that contained at least one secondary diagnosis code[8] for a health-care-acquired condition and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code. We also reviewed the Medicaid paid claim data for these services to identify claim lines that had HCPCS modifiers indicating that the claim lines contained other PPCs.

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

[6] Under the State plan, claims must contain the applicable Healthcare Common Procedure Coding System (HCPCS) modifier. The HCPCS modifier further describes a procedure code without changing the definition of the code.

[7] A claim can have multiple claim lines. Each claim line represents a service provided.

[8] We reviewed the secondary, not primary, diagnosis codes for health-care-acquired conditions because the ACA's payment prohibition pertains only to secondary diagnosis codes.

Appendix A describes our audit scope and methodology.

FINDING

The State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. For our audit period, we identified 4,766 claim lines totaling $6,080,902 ($4,333,025 Federal share) that contained PPCs and (1) a POA code indicating that the condition was not present on admission, (2) a POA code indicating that the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) no POA code.[9]

The State agency did not have internal controls to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $6,080,902 ($4,333,025 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement.[10] Therefore, we have set aside this amount for resolution by CMS and the State agency.

FEDERAL AND STATE REQUIREMENTS

The ACA and Federal regulations prohibit Federal payments for health-care-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Federal regulations and the Idaho State plan do not deny payment for an entire claim that contains a PPC but instead limit the reduction of the payment to the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and State Plan Amendment (SPA) 12-012, Attachment 4.19-B § B, respectively). Further, the Idaho State plan provides that any claims related to health-care-acquired conditions or other PPCs will be reviewed to find any related charges, and payment for the claims will be denied or recovered (SPA Attachment 4.19-B § a).

Hospitals are required to report health-care-acquired conditions using the appropriately designated POA codes and to report other PPCs with the appropriately designated HCPCS modifier[11] (SPA Attachments 4.19-A § a and 4.19-B § a, respectively).

Portions of a claim for inpatient hospital services that contain health-care-acquired conditions or other PPCs with dates of service on or after September 1, 2012, are not eligible for Medicaid reimbursement under the Idaho State plan. Specifically, the State agency does not make payments for (1) health-care-acquired conditions that are coded with POA codes "N" or "U" or are missing POA codes and (2) other PPCs (SPA Attachments 4.19-A § a and 4.19-B § a, respectively).

[9] The PPCs we identified were health-care-acquired conditions. We did not identify other PPCs in the claim lines we reviewed.

[10] In April 2016, the State agency provided support that it had reversed or reprocessed 3,673 claim lines totaling $4,662,818. Because our fieldwork was concluded, we did not review the support for accuracy or completeness.

[11] The State agency uses a specific HCPCS modifier to identify each of the three conditions classified as other PPCs.

THE STATE AGENCY CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

The State agency claimed $6,080,902 ($4,333,025 Federal share) for Medicaid inpatient hospital services related to treating certain PPCs. The claimed amount represented 4,766 claim lines that contained PPCs, consisting of:

- 3,272 claim lines that (1) had a POA code indicating that either the condition was not present at the time of inpatient admission or the documentation in the patient's medical record was not sufficient to determine whether the condition was present on admission or (2) were missing at least 1, but not all, POA codes and

- 1,494 claim lines that did not have a POA code for any of the diagnoses identified on the claim line.

Although Federal regulations prohibited the State agency from paying for services related to PPCs, and under its State plan, the State agency would no longer pay for inpatient hospital services related to PPCs as of September 1, 2012, the State agency did not have internal controls to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $6,080,902 ($4,333,025 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by CMS and the State agency.

During our audit, the State agency was in the process of developing and revising edits within its MMIS to identify and deny payment of claims that contained PPCs. In January 2014, the State agency implemented edits to identify claims that contained PPCs but did not review the claims to determine whether payment should be denied or adjusted. The State agency revised the edits in February 2015 to deny payment of claims that contained PPCs.[12] State agency officials indicated that the edits were fully implemented as of August 2015 after the edits were further revised to identify all diagnosis codes for health-care-acquired conditions. Because the edits were not fully implemented until after our audit period, we did not determine whether they were effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the $4,333,025 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount,

[12] The edits denied claims that contained health-care-acquired conditions and had the POA codes "N" or "U" or were missing POA codes. The edits also denied claims that contained HCPCS modifiers for other PPCs. When a claim was denied, the provider was instructed to remove the costs of services related to treating PPCs and to resubmit the claim so that the remaining services could be paid.

- review all paid claims after our audit period for inpatient hospital services to determine whether payments should be adjusted for any claims that contained PPCs and refund to the Federal Government its share of any unallowable amounts, and

- ensure that its MMIS edits are fully implemented and effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. Regarding our first and second recommendations, the State agency commented that it had implemented the regulations related to health-care-acquired conditions with the understanding that critical access hospitals were exempt from regulations prohibiting Federal payments for these conditions.[13] The State agency said that it understands CMS's position on this requirement more clearly after our audit and will make policy changes "to align with the CMS interpretation."[14]

The State agency's comments are included in their entirety as Appendix B.

[13] The State agency commented that one claim from a critical access hospital was included in our finding.

[14] Federal regulations prohibit Federal payments for health-care-acquired conditions occurring in *any* inpatient hospital setting (42 CFR § 447.26).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, through June 30, 2014, the State agency claimed $613,692,372 ($436,818,970 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify claim lines that contained at least one secondary diagnosis code for a health-care-acquired condition and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code reported (i.e., the POA code was missing). We also reviewed the Medicaid paid claim data for these services to identify claim lines that had HCPCS modifiers indicating that the claim lines contained other PPCs. We did not determine whether the hospitals (1) reported all PPCs, (2) assigned correct diagnosis codes or POA codes, or (3) claimed services that were properly supported.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from February 2015 through January 2016 and performed fieldwork at the State agency's office in Boise, Idaho.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, Federal and State guidance, and the State plan;

- held discussions with CMS officials to gain an understanding of (1) inpatient hospital services and the processing of inpatient hospital claims and (2) CMS guidance furnished to the State agency concerning payments for PPCs;

- held discussions with State agency officials to gain an understanding of inpatient hospital services and PPCs and any action taken (or planned) by the State agency to identify and prevent payment of services related to treating PPCs;

- reviewed the State agency's internal controls over the accumulation, processing, and reporting of inpatient hospital service expenditures and PPCs;

- obtained a claim database containing inpatient hospital service expenditures from the State agency's MMIS for claims paid during the audit period;

- reconciled the inpatient hospital service expenditures claimed by the State agency on the Form CMS-64 with supporting schedules and the claim database;

- reviewed the claim data to identify claim lines that contained health-care-acquired conditions and had the POA codes "N" or "U" or did not have a POA code reported;

- reviewed the claim data to identify whether any claim lines had HCPCS modifiers indicating that the claim lines contained other PPCs; and

- discussed the results of our audit with State agency officials.

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

APPENDIX B: STATE AGENCY COMMENTS

IDAHO DEPARTMENT OF
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August 22, 2016

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
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90 – 7th Street, Suite 3-650
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Dear Ms. Ahlstrand:

Thank you for your July 26, 2016 letter and draft report A-09-15-02013, *Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions.* Idaho Medicaid appreciates the opportunity to provide comments to the recommendations included in the draft Office of Inspector General (OIG) report. Our responses for each recommendation are included below.

OIG Recommendation 1: *We recommend that the State agency work with CMS to determine what portion of the $4,333,025 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount.*

Idaho Medicaid Response:

We concur with this recommendation. The 4,776 claim lines identified in the OIG evaluation were associated with 264 claims. Idaho Medicaid has worked with providers to adjust or recoup 214 of those claims, resolving $5,300,137 or 87% of the identified total. Recoupment or appropriate adjustment is underway for the remaining claims identified in the audit.

One claim from a Critical Access Hospital (CAH) was included in the OIG audit finding. Idaho Medicaid implemented the Health Care Acquired Conditions (HCAC) regulations with the understanding that Critical Access Hospitals (CAHs) were exempt from regulations prohibiting Federal payments for health-care-acquired conditions. We understand CMS's position on this requirement more clearly after this audit. Idaho will be making policy changes to align with the CMS interpretation in the future. However, we do feel that our initial understanding was not inconsistent with the laws and regulations governing HCAC.

OIG Recommendation 2: *We recommend that the State agency review all paid claims after our audit period for inpatient hospital services to determine whether payments should be adjusted for any claims that contained PPCs and refund to the Federal Government its share of any unallowable amounts.*

Idaho Medicaid Response:

We concur with this recommendation. As noted above, Idaho Medicaid implemented the Health Care Acquired Conditions (HCAC) regulations with the understanding that Critical Access Hospitals (CAHs) were exempt from regulations prohibiting Federal payments for health-care-acquired conditions. While Idaho believes its initial interpretation was consistent with Federal law and regulation, we will review these claims in keeping with the stated CMS policy.

OIG Recommendation 3: *We recommend that the State agency ensure that its MMIS edits are fully implemented and effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.*

Idaho Medicaid Response:

We concur with this recommendation. Idaho Medicaid has made the required changes to our system controls to include the appropriate edits to ensure compliance for Idaho Acute Care Hospital inpatient claims.

We appreciate consideration of our responses to the draft audit report.

Sincerely,

Lisa Hettinger

LISA HETTINGER
Medicaid Director

LH/kb

CC: Matt Wimmer, Administrator, Division of Medicaid
Cathy Libby, Deputy Administrator, Medicaid
Gerald Illies, Office of Inspector General