Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IOWA COMPLIED WITH MOST FEDERAL REQUIREMENTS PROHIBITING MEDICAID PAYMENTS FOR INPATIENT HOSPITAL SERVICES RELATED TO PROVIDER-PREVENTABLE CONDITIONS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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May 2018
A-07-17-03221

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: May 2018
Report No. A-07-17-03221

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG 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. The Centers for Medicare & Medicaid Services (CMS) delayed enforcement of these regulations until July 1, 2012, to allow States time to develop and implement new payment policies. We conducted this review to determine whether Iowa complied with these regulations for inpatient hospital services. Under the Iowa State plan, September 1, 2011, is the effective date of the new payment policy for Iowa. This review is one in a series of OIG reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

Our objective was to determine whether Iowa complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs.

How OIG Did This Review

We reviewed the Medicaid paid claim data for inpatient hospital services from October 1, 2011, through September 30, 2015, to identify claims that contained at least one secondary diagnosis code for a PPC. We reviewed Iowa's claimed inpatient hospital expenditures to determine whether Iowa adjusted payments to exclude the portions of the claims attributed to the PPCs.

Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions

What OIG Found

Iowa complied with most of the Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating PPCs, because its automated system edits identified claims submitted by the hospitals for those services that related to treating PPCs and reduced the related payment amounts accordingly.

However, Iowa incorrectly excluded certain inpatient hospital types from the Federal PPC reporting and payment reduction requirements and did not require those hospital types to populate the present-on-admission (POA) indicator code field on their claims. Furthermore, Iowa incorrectly included diagnosis codes that should not have been subject to the payment reduction because CMS had not designated those codes as complications or comorbidities (CCs) or major CCs (MCCs). Iowa misinterpreted some specific portions of the requirements related to the hospital types subject to PPC reporting requirements.

What OIG Recommends

We recommend that Iowa issue a revised Informational Letter to require that all inpatient hospital types report PPCs and appropriately reduce payments for PPCs for all future claims in accordance with Federal requirements. We also made procedural recommendations to Iowa that it obtain the POA codes for inpatient hospital types that were excluded due to the State agency's misinterpretation of the Federal requirements and identify and adjust any paid claims as necessary, revise its claims processing system edits, and identify any paid claims that had an improper payment reduction from diagnosis codes that were not considered a CC or MCC and make the proper adjustments.

Iowa did not concur with our recommendations. Iowa stated that it followed CMS Medicare guidance that specifically exempts certain hospitals. Iowa added that no corrective action was necessary for its system edits because it updated its claims system on October 1, 2015, and said that it can identify but not adjust claims that are 3 years old or older.

We maintain that our recommendations remain valid. Entities that operate as Medicaid inpatient hospitals are not exempt from payment reduction. We did not review Iowa's updated claims system because it was implemented after our audit period. Finally, because Iowa can identify the claims that had an improper payment reduction, it has the ability to adjust those payments.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71703221.asp.

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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. 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. Under the Iowa State plan, September 1, 2011, is the effective date of the new payment policy for that State. We conducted this review to determine whether Iowa complied with these regulations for inpatient hospital services. This review is one in a series of Office of Inspector General (OIG) reviews of States' Medicaid payments for inpatient hospital services related to PPCs. (See Appendix B for a list of related OIG reports.)

OBJECTIVE

Our objective was to determine whether the Iowa Department of Human Services (State agency) complied with Federal and State requirements prohibiting Medicaid payments 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). From October 1, 2011, through September 30, 2015, Iowa's FMAP ranged from 55 percent to 63 percent.

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims through certain diagnosis codes.[1] Diagnosis codes are used to identify a patient's health conditions.

[1] 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.

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

- **Health-care-acquired conditions** are conditions acquired in any inpatient hospital 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 Social Security Act § 1886(d)(4)(D)(iv)).[2] These conditions include, among others, surgical site infections and foreign objects retained after surgery (76 Fed. Reg. 32817 (Jun. 6, 2011)).

- **Other PPCs** are certain conditions occurring in any health care setting that a State identifies in its 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 may 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

The absence of POA codes does not exempt States from prohibiting payments for services related to PPCs.

[2] These conditions are identified by CMS 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)).

[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.

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 (42 CFR § 447.26). Federal regulations authorize States to identify other PPCs for which Medicaid payments will also be prohibited (42 CFR § 447.26(b)).[5] Both Federal regulations (42 CFR § 447.26(c)(3)) and the Iowa 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.

The Iowa State plan and a State agency Informational Letter prohibit payment for the portion of a claim attributable to a PPC.[6] Payment is prohibited for claims for inpatient hospital services that contain a PPC for which a POA code indicates that (1) the condition was not present at the time of inpatient admission or (2) the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission. The State agency Informational Letter also prohibits payment for PPC claims that require a POA code but did not have a POA code reported (i.e., the POA code was missing on the claim). Payments are not reduced for conditions that were present before admission or that the provider was clinically unable to determine were present before admission.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2015 (audit period), the State agency claimed $534,629,989 ($314,390,519 Federal share) for inpatient hospital services.[7, 8] We reviewed the Medicaid paid claim data for the inpatient hospital services and identified claims that contained

[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.

[6] The Iowa State plan indicates that an *admission* date of September 1, 2011, is the effective date of this policy, while the State agency Informational Letter indicates that a *discharge* date of September 1, 2011, is the effective date. For our review we used the discharge date as the effective date because the State agency said that it regarded the Informational Letter as the more up-to-date document.

[7] We selected this audit period to be as closely aligned as possible with the effective date of the State plan for PPCs (Appendix C). The audit period encompassed the most current data available at the time we initiated our review.

[8] Medicare crossover claims were not included in our review. The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with kidney disease. Medicaid pays part or all of the Medicare deductibles and coinsurance to providers for claims submitted on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. These claims are called Medicare crossover claims.

at least one secondary diagnosis code[9] for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating that 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.

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

Appendix A describes our audit scope and methodology.

FINDINGS

The State agency complied with most Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs, because its automated system edits identified claims submitted by the hospitals for those services that related to treating PPCs and reduced the related payment amounts accordingly.

However, the State agency incorrectly excluded certain inpatient hospital types from the Federal PPC reporting and payment reduction requirements. State agency policy (in the form of an Informational Letter to inpatient hospitals) and automated system edits specifically excluded those inpatient hospital types from these requirements, and because of this policy, the State agency did not require these hospital types to populate the POA code field in the claims they submitted.

Furthermore, although the State agency did reduce the payments related to treating PPCs, its system edits incorrectly included diagnosis codes that should not have been subject to the payment reduction because CMS had not designated those codes as complications or comorbidities (CCs) or major CCs (MCCs).[10]

The State agency's instances of noncompliance with Federal requirements occurred because the State agency (1) misinterpreted some specific portions of the requirements related to the hospital types subject to PPC reporting requirements and to the implementation of the list of Medicare hospital-acquired conditions and (2) disseminated incorrect guidance in the form of a State agency Informational Letter to inpatient hospitals.

[9] We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA's payment prohibition pertains only to secondary diagnosis codes. The paid claim data included up to 24 secondary diagnosis codes for each claim.

[10] Comorbidity means more than one condition is present in the same person at the same time.

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). Both Federal regulations and the Iowa State plan state that payment is not denied for an entire claim that contains a PPC; instead, the requirements 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) 11-018, Attachment 4.19-A, respectively).

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 (Jun. 6, 2011)). The list of Medicare hospital-acquired conditions includes 14 categories of conditions, such as falls and trauma. The list provides diagnosis codes and diagnosis code/procedure code combinations that are considered Medicare hospital-acquired conditions. Some categories include a range of diagnosis codes, but only diagnosis codes within the range that are defined as CCs or MCCs are considered Medicare hospital-acquired conditions (76 Fed. Reg. 25789, 25810 (May 5, 2011)).

For additional details on these Federal and State requirements, see Appendix C.

THE STATE AGENCY COMPLIED WITH MOST FEDERAL REQUIREMENTS PROHIBITING MEDICAID PAYMENTS FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

The State Agency Excluded Some Hospital Types From Federal Provider-Preventable Condition Reporting and Payment Reduction Requirements

The State agency did not always comply with Federal requirements prohibiting Federal payments for inpatient hospital services related to treating certain PPCs. Federal Medicaid requirements specify that all inpatient hospital types are subject to Federal PPC reporting and payment reduction requirements; however, in a published policy that took the form of an Informational Letter to inpatient hospitals (No. 1108, effective September 1, 2011),[11] the State agency incorrectly excluded certain inpatient hospital types from these requirements. Specifically, the State agency excluded critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals. To execute this policy, the State agency implemented automated system edits that excluded these hospital types from the payment reduction requirements; in addition, the State agency did not require these hospital types to populate the POA code field in the claims they submitted.

[11] This Informational Letter superseded two earlier versions (Nos. 1038 and 1058); however, the relevant language that we summarize in the remainder of this paragraph did not change from one version of this letter to the next.

Although the State agency did not require these inpatient hospital types to populate the POA code field when submitting claims, the hospitals did report the diagnosis codes on the claims. As part of our audit work, we evaluated claims submitted by these types of hospitals, using the diagnosis codes reported on the claims. We did so to test whether PPC payments had been received for any claims submitted by these inpatient hospital types, but our testing did not identify any such payments.

For the inpatient hospitals that the State agency did not specifically exclude from the PPC reporting and payment reduction requirements, the State agency had automated system edits that correctly adjusted claims submitted by hospitals for services related to treating PPCs. Specifically, the edits automatically excluded the PPCs from the list of related diagnosis codes and automatically reduced the related payment amounts.

The State Agency Included Some Diagnosis Codes Not Included in the List of Medicare Health-Acquired Conditions

The State agency did not comply with Federal requirements when developing its system edits related to the implementation of the list of Medicare hospital-acquired conditions. Federal requirements state that for a diagnosis code to be considered a PPC by CMS, the code must appear on the list of Medicare hospital-acquired conditions and must also be a CC or MCC; alternatively, a State may identify other PPCs that must be identified, and approved by CMS, in the State plan.

When implementing its system edits, the State agency used the ranges of diagnosis codes from the list of Medicare hospital-acquired conditions. However, some of the diagnosis codes within those ranges were not CCs or MCCs. Because the State agency's system edits used ranges of codes that included some diagnosis codes that CMS has not designated as CCs or MCCs, the edits could have incorrectly identified these diagnosis codes and improperly reduced the related payment amounts.

THE STATE AGENCY MISINTERPRETED SOME FEDERAL REQUIREMENTS

The State agency's instances of noncompliance with Federal requirements occurred because the State agency (1) misinterpreted some specific portions of the requirements related to the hospital types subject to PPC reporting requirements and to the implementation of the list of Medicare hospital-acquired conditions and (2) disseminated incorrect guidance in the form of a State agency Informational Letter to inpatient hospitals.

RECOMMENDATIONS

We recommend that the State agency:

- issue a revised Informational Letter to require that all inpatient hospital types, including critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals, report PPCs and appropriately reduce payments for PPCs for all future claims in accordance with Federal requirements;

- obtain the POA codes for inpatient hospital types that were excluded due to the State agency's misinterpretation of the Federal requirements and identify and adjust any paid claims that were subject to payment reduction as a result of treating a PPC;

- revise its claims processing system edits to ensure that the payment reduction applies only to PPCs by including only those diagnosis codes that are included in the list of Medicare hospital-acquired conditions and that are considered a CC or MCC; and

- identify any paid claims that had an improper payment reduction from diagnosis codes that were not considered a CC or MCC and make the proper adjustments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our recommendations. For our first and second recommendations, the State agency stated that it followed CMS Medicare guidance, which specifically exempts the inpatient hospital types that we listed, and therefore does not believe that any claims need to be adjusted. For our third recommendation, the State agency said that no corrective action was necessary because it updated its claims system on October 1, 2015. For our fourth recommendation, the State agency said that although it can identify the claims in question, it is unable to adjust submitted claims that are 3 years old or older.

The State agency's comments appear in their entirety as Appendix D.[12]

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our recommendations remain valid. Regarding our first and second recommendations, the ACA (footnote 4) requires that hospital-acquired conditions identified under Medicare rules are applicable to *all* entities that

[12] Although the State agency's footers in Appendix D state that there are five pages of written comments, we have confirmed with the State agency that that is a typographical error and that the comments in their entirety consist of just four pages.

operate as Medicaid inpatient hospitals.[13] Accordingly, hospitals that are exempt from the Medicare requirements are *not* exempt from the Medicaid requirements prohibiting Federal payments for inpatient hospital services related to treating certain PPCs. Regarding our third recommendation, the October 1, 2015, date on which the State agency implemented its updated claims system occurred after our audit period had ended (September 30, 2015). For that reason, we did not review the updated system to determine whether it was correctly applying the payment reduction when processing claims.

Regarding our fourth recommendation, because the State agency can—as it acknowledged in its written comments—identify the claims that had an improper payment reduction from diagnosis codes that were not considered a CC or MCC, it has the ability to adjust those payments. The State agency's reference to claims that are 3 years old or older could apply if the payments in question were to CMS or at the level of Medicare administrative contractors; that reference does not apply to adjustments to Medicaid payments that the State agency made for the inpatient hospital services that are the subject of this review.

[13] 76 Fed. Reg. 32816, 32827 (Jun. 6, 2011).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For our audit period, the State agency claimed $534,629,989 ($314,390,519 Federal share) for inpatient hospital services (footnotes 7 and 8). We reviewed the Medicaid paid claim data for the inpatient hospital services only, to identify claims that contained at least one secondary diagnosis code (footnote 9) for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating that 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 on the claim). We did not determine whether the hospitals reported all PPCs, assigned correct diagnosis codes or POA codes, or 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 work, which included fieldwork at the State agency in Des Moines, Iowa, from August 2016 to January 2017.

METHODOLOGY

To accomplish our objective, we:

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

- 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 Medicaid Management Information System for claims paid during the audit period;

- reconciled the inpatient hospital service expenditures claimed by the State agency on the form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement with supporting schedules and the claim database for four quarters of our 4-year audit period (that is, for one judgmentally selected quarter from each year);

- reviewed the paid claim data to identify claims that contained PPCs and that had the POA codes "N" or "U" or that were missing a POA code, and evaluated these data to test whether PPC payments had been received for any claims submitted by the types of inpatient hospitals that the State agency had excluded from Federal PPC reporting and payment reduction requirements;

- tested the State agency's system edits by having the State agency first run a claim through its system using a PPC diagnosis code and POA code "Y," then run the same claim again changing only the POA code to "N" and leaving all other variables the same; and

- discussed the results of our audit with State agency officials on February 23, 2017, and provided them with updated results on September 14, 2017.

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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims	A-06-16-08004	3/6/2018
Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-05-15-00033	9/20/16
Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-09-14-02012	9/15/16
Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-09-15-02013	9/15/16

APPENDIX C: FEDERAL AND STATE REQUIREMENTS FOR PROVIDER-PREVENTABLE CONDITIONS

FEDERAL REQUIREMENTS

Federal Regulations

The ACA and Federal regulations prohibit Federal payments for health-care-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Both Federal regulations and the Iowa 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 SPA 11-018, Attachment 4.19-A, respectively).

Federal regulations define health-care-acquired condition as a condition identified as a Medicare hospital-acquired condition, other than deep vein thrombosis or pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients (42 CFR § 447.26(b)). Further, "the Secretary [of Health and Human Services] has authority to update the Medicare HAC [hospital-acquired condition] list, as appropriate. As such, States are required to comply with subsequent updates or revisions . . . ." (76 Fed. Reg. 32816, 32820 (Jun. 6, 2011)). In addition, the definition of other PPCs allows States to expand, based on specific criteria and with CMS approval, their designated conditions identified for nonpayment (76 Fed. Reg. 32816, 32819 (Jun. 6, 2011)).

Federal Medicaid regulations state that health-care-acquired condition requirements apply to any inpatient hospital setting and that other PPCs apply to any health care setting (42 CFR § 447.26(b)).

Federal Register

The list of Medicare hospital-acquired conditions published by CMS can be found in the Federal Register and on the Medicare website.[14] The list of Medicare hospital-acquired conditions indicates that the hospital-acquired condition codes must be designated as a CC or MCC (73 Fed. Reg. 48434, 48473 (Aug. 19, 2008)). Furthermore, CMS has the authority to update the list of Medicare hospital-acquired conditions under the provisions of the section 1886(d)(4)(D) of the Social Security Act, and States are required to comply with subsequent updates (76 Fed. Reg. 32816, 32820 (Jun. 6, 2011)).

[14] At https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html (accessed Feb. 28, 2018).

STATE REQUIREMENTS

State Medicaid Plan

The Iowa State plan specifies that the State agency does not make additional payments for services on inpatient hospital claims that are attributable to PPCs and that are coded with POA codes "N" or "U."

State Informational Letter

Iowa Department of Human Services, Informational Letter No. 1108 (effective September 1, 2011; footnote 11), excludes the following hospital types from PPC reporting and payment reduction requirements: critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals.

This Informational Letter applies to claims with discharge dates on and after September 1, 2011. In addition, the Letter states that the State agency's PPC conditions are consistent with CMS's hospital-acquired condition policy.

Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

Patrick J. Cogley
Regional Inspector General for Audit Services
HHS-OIG-Office of Audit Services
Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: *Iowa Complied with Most Federal Requirements Prohibiting Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions,* Draft Report, A-07-17-003221

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) on the March 16, 2018, draft report concerning Office of Inspector General's (OIG) review of the inpatient hospital provider-preventable conditions payments processed by DHS.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the final report. DHS strives to administer the program in compliance with applicable Federal and State law, regulations, and other policies. DHS is committed to working with CMS to resolve the issues identified in this audit review and are appreciative of the hard work your staff has undertaken relative to this audit.

Questions about the enclosed response can be addressed to:

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Sincerely,

/s/

Jerry R. Foxhoven
Director

cc: Megan Seehafer, Audit Manager

IOWA DEPARTMENT OF HUMAN SERVICES
RESPONSE TO OIG DRAFT REPORT:

Iowa Complied with Most Federal Requirements Prohibiting Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions,
Draft Report, A-07-17-003221

Background

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. The Centers for Medicare & Medicaid Services (CMS) delayed its enforcements of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. Under the Iowa State Plan, September 1, 2011, is the effective date of the new payment policy for Iowa. OIG conducted this review to determine whether Iowa complied with these regulations for inpatient hospital services.

The Iowa State Plan and a Department of Human Services (DHS) Informational Letter prohibit payment for the portion of a claim attributable to a PPC. Payment is prohibited for claims for inpatient hospital services that contain a PPC for which a present-on-admission indicator code (POA code) indicates that (1) the condition was not present at the time of inpatient admission, or (2) the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission. The DHS Informational Letter also prohibits payment for the PPC claims that require a POA code but did not have a POA code reported (i.e., the POA code was missing on the claim). Payments are not reduced for conditions that were present before admission or that the provider was clinically unable to determine were present before admission.

For this audit, OIG reviewed the Department of Human Services claim data for the inpatient hospital services and identified claims that contained at least one secondary diagnosis code for a PPC and that (1) had a POA code indicating that the condition was not present on admission, (2) had a POA code indicating that the documentation in the patient's medical record was insufficient to determine whether the conditions was present on admission, or (3) did not have a POA code reported for the period October 1, 2011, through September 30, 2015 (audit period).

OIG Findings and Recommendations

Iowa DHS complied with most federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain provider-preventable conditions.

Iowa DHS excluded some hospital types from federal provider-preventable condition reporting and payment reduction requirements.

Iowa DHS included some diagnosis codes not included in the list of Medicare health-acquired conditions.

Iowa DHS misinterpreted some federal requirements.

OIG recommends that DHS:

- Issue a revised Informational Letter to require that all inpatient hospital types, including critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals, report PPCs and appropriately reduce payments for PPCs for all future claims in accordance with Federal requirements;
- Obtain the POA codes for inpatient hospital types that were excluded due to DHS' misinterpretation of the Federal requirements and identify and adjust any paid claims that were subject to payment reduction as a result of treating a PPC;
- Revise its claim processing system edits to ensure that the payment reduction applies only to PPCs by including only those diagnosis codes that are included in the list of Medicare hospital-acquired conditions and that are considered a CC or MCC; and
- Identify any paid claim that had an improper payment reduction from diagnosis codes that were nor considered a CC or MCC and make the proper adjustments.

DHS Response

OIG Recommendation #1 – Issue a revised Informational Letter to require that all inpatient hospital types, including critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals, report PPCs and appropriately reduce payments for PPCs for all future claims in accordance with Federal requirements.

DHS does not concur with this recommendation. DHS followed CMS guidance which specifically exempts the hospitals listed. See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals.html for this exemption.

OIG Recommendation #2 – Obtain the POA codes for inpatient hospital types that were excluded due to DHS' misinterpretation of the Federal requirements and identify and adjust any paid claims that were subject to payment reduction as a result of treating a PPC.

DHS does not concur with this recommendation. As stated in OIG recommendation #1, DHS was following CMS guidance for the inpatient hospital types and therefore do not believe that any claims need to be adjusted.

OIG Recommendation #3 – Revise its claim processing system edits to ensure that the payment reduction applies only to PPCs by including only those diagnosis codes that are included in the list of Medicare hospital-acquired conditions and that are considered a CC or MCC.

DHS does not concur with this recommendation. No corrective action is needed because MS-DRG version 33 was implemented into the claims system on October 1, 2015. This version has POA built-in and hard coding is no longer done in the claim system.

OIG Recommendation #4 – Identify any paid claim that had an improper payment reduction from diagnosis codes that were not considered a CC or MCC and make the proper adjustments.

DHS does not concur with this recommendation. DHS is able to identify claims, but are unable to adjust claims submitted 3 years or older. No corrective action can occur.