

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MISSOURI DID NOT COMPLY WITH
FEDERAL AND STATE
REQUIREMENTS PROHIBITING
MEDICAID PAYMENTS FOR
INPATIENT HOSPITAL SERVICES
RELATED TO PROVIDER-
PREVENTABLE CONDITIONS**

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**May 2018
A-07-16-03216**

Office of Inspector General

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Report in Brief

Date: May 2018

Report No. A-07-16-03216

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 Missouri complied with these regulations for inpatient hospital services. This is one in a series of reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

Our objective was to determine whether Missouri 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 July 1, 2012 (the effective date of the new payment policy for Missouri, under its State plan), through September 30, 2015, to identify claims that contained at least one secondary diagnosis code for a PPC. We reviewed Missouri's claimed inpatient hospital expenditures to determine whether Missouri adjusted payments to exclude the portions of the claims attributed to the PPCs.

Missouri Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions

What OIG Found

Missouri did not comply with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs, because it did not follow its State plan to perform a retrospective review of the claims with diagnoses identified as PPCs ("Pay But Report" status). In addition, Missouri paid inpatient hospital claims in which the present-on-admission (POA) indicator data field had been left blank. We identified inpatient hospital claims totaling \$2.7 million (\$1.7 million Federal share) that contained a diagnosis code identified as a PPC and certain POA codes.

Furthermore, Missouri incorrectly excluded some diagnosis codes that were subject to the payment reduction. In addition, Missouri incorrectly included other diagnosis codes that should not have been subject to the payment reduction.

What OIG Recommends

We recommend that Missouri work with CMS to determine what portion of the \$1.7 million (Federal share) was unallowable for Federal Medicaid reimbursement and refund that portion to the Federal Government. We also made procedural recommendations to Missouri that it develop policies and procedures to ensure that all claims with PPCs that had certain POA codes are identified and adjusted in accordance with Federal and State requirements and to ensure that the correct diagnosis codes are being used to identify PPCs.

Missouri concurred with our findings and described procedures that it had implemented or planned to implement to address our recommendations. Missouri said that it had implemented procedures to review all inpatient hospital claims to determine whether the payments should be adjusted for claims containing PPCs and added that its contractor had retrospectively processed inpatient hospital claims for our audit period and had identified an estimated recoupment (both Federal and State funds) of almost \$220,000 for claims with PPCs.

We commend Missouri for taking prompt corrective actions in response to our recommendations but note that we did not review the implemented procedures that Missouri outlined to determine their effectiveness.

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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. Subsequently, CMS approved Missouri's State Plan Amendment (SPA) with that July 1, 2012, effective date. We conducted this review to determine whether Missouri 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 Missouri Department of Social 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 July 1, 2012, through September 30, 2015, Missouri's FMAP ranged from 61 percent to 64 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 on claims 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 Missouri 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 Missouri State plan states that the Medicaid Management Information System (MMIS) will flag for nonpayment all claims with diagnosis codes identified as health-care-acquired conditions. Of these claims, those indicating the diagnosis was “not present on admission” will edit to “Pay But Report” for retrospective clinical review of potential recoupment of inpatient days associated with the health-care-acquired condition. The State plan also says that the MMIS will deny payment for claims in which the POA indicator data field is not filled with a valid POA indicator (SPA 13-08, Attachment 4.19-A).

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through September 30, 2015 (audit period), the State agency claimed \$1,853,574,108 (\$1,155,213,041 Federal share) for inpatient hospital services.^{6, 7} We reviewed the Medicaid paid claim data for the inpatient hospital services and identified claims that contained at least one secondary diagnosis code⁸ 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

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 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.

⁷ 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.

⁸ 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 four secondary diagnosis codes for each claim.

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 did not comply with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs, because it did not follow the provision of its CMS-approved State plan directing it to perform a retrospective clinical review of the claims with diagnosis codes identified as PPCs (“Pay But Report” status). In addition, the State agency paid inpatient hospital claims in which the POA indicator data field had been left blank. We identified inpatient hospital claims totaling \$2,747,829 (\$1,709,925 Federal share) that contained a diagnosis code identified as a PPC 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. Therefore, we are setting aside this amount for resolution by CMS and the State agency.

Furthermore, when developing and implementing its system edits, the State agency incorrectly (1) excluded some diagnosis codes that were on the list of Medicare hospital-acquired conditions and (2) included other diagnosis codes that should not have been subject to payment reduction because CMS had not designated those codes as complications or comorbidities (CCs) or major CCs (MCCs).⁹

The State agency’s noncompliance with Federal requirements occurred because the State agency (1) did not develop policies and procedures to review the claims that were placed in the “Pay But Report” status and (2) did not correctly implement the list of Medicare hospital-acquired conditions into its system edits.

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 Missouri 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 SPA 13-08, Attachment 4.19-A).

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

⁹ Comorbidity means more than one condition is present in the same person at the same time.

(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)).

The Missouri State plan states that the MMIS will flag for nonpayment all claims with diagnosis codes identified as health-care-acquired conditions. Of these claims, those indicating that the diagnosis was “not present on admission” will edit to “Pay But Report” for retrospective clinical review of potential recoupment of inpatient days associated with the health-care-acquired conditions. The MMIS will deny payment for claims in which the POA indicator data field is not filled with a valid POA indicator (SPA 13-08, Attachment 4.19-A).

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

THE STATE AGENCY DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS PROHIBITING MEDICAID PAYMENTS FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

The State Agency Did Not Review or Adjust Claims Containing Diagnosis and Present-on-Admission Codes Identified as Provider-Preventable Conditions

The State agency did not comply with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs. The State agency did not follow the provision of its CMS-approved State plan directing it to perform a retrospective clinical review of potential recoupment of inpatient days associated with PPCs. The State agency flagged claims with diagnosis codes identified as PPCs that were “not present on admission” as “Pay But Report,” but it did not perform the required clinical review retrospectively.

In addition, the State agency paid inpatient hospital claims in which the POA indicator data field had been left blank instead of being filled with a valid POA indicator; these claims should therefore have been denied.

The State agency did not develop or implement any policies and procedures for the review of those claims that were placed in the “Pay But Report” status to determine whether the payments should have been adjusted for claims containing PPCs that had certain POA codes or that were missing POA codes. As a result, the State agency did not determine the unallowable portion of the \$2,747,829 (\$1,709,925 Federal share) that pertained to services related to treating PPCs and that should not have been claimed for Federal Medicaid reimbursement. Therefore, we are setting aside this amount for resolution by CMS and the State agency.

During our audit, the State agency was in the process of developing policies and procedures to review the claims that had been placed in the “Pay But Report” status. These new policies and procedures had not been implemented by the end of our fieldwork; therefore, we were unable to determine whether they were effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

The State Agency Did Not Correctly Implement the List of Medicare Hospital-Acquired Conditions Into Its System Edits

The State agency did not comply with Federal and State 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 incorrectly applied the list of Medicare hospital-acquired conditions. Specifically, the State agency incorrectly excluded from its system edits some diagnosis codes that were on the list of Medicare hospital-acquired conditions. For that reason, the State agency’s system edits may not have properly identified these diagnosis codes as potential PPCs. In other cases, the State agency included in its system edits some diagnosis codes that—although they were within the range of diagnosis codes that appeared on the list of Medicare hospital-acquired conditions—had not been designated as CCs or MCCs by CMS. These diagnosis codes should therefore not have been subject to payment reduction. But because the State agency’s system edits included these diagnosis codes, the edits could have incorrectly identified these codes.¹⁰

THE STATE AGENCY DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The State agency’s noncompliance with Federal requirements occurred because the State agency did not develop or implement policies and procedures to review the claims that were placed in the “Pay But Report” status to determine whether the payments should have been adjusted for claims containing PPCs that had certain POA codes or that were missing POA codes. In addition, the State agency did not correctly implement the list of Medicare hospital-acquired conditions into its system edits, such that (1) it incorrectly excluded from those edits some diagnosis codes that appeared on that list and (2) in other cases, included in those edits some diagnosis codes that CMS had not designated as CCs or MCCs and that therefore should not have been subject to payment reduction.

¹⁰ As previously stated, the State agency did not perform the required retrospective clinical reviews to recoup potential overpayments. Consequently, the State agency’s inclusion of the undesignated diagnosis codes in its system edits did not result in any improper payment reductions. Nonetheless, the edits should be revised in the future.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the \$1,709,925 (Federal share) was unallowable for Federal Medicaid reimbursement and refund that unallowable portion to the Federal Government;
- develop and implement policies and procedures to ensure that all claims with PPCs that have certain POA codes are identified and adjusted in accordance with Federal and State requirements;
- enhance its system edits to ensure that all claims that lack a valid POA code in the POA indicator data field are denied;
- ensure that its system edits use all of the diagnosis codes that appear on the list of Medicare hospital-acquired conditions when identifying PPCs; and
- revise its system edits to ensure that the diagnosis codes used for payment reductions include only those codes that are included in the list of Medicare hospital-acquired conditions and that CMS has designated as CCs or MCCs.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our findings and described procedures that it had implemented or planned to implement to address our recommendations. The State agency said that it had “implemented procedures on November 1, 2017 to review all inpatient hospital claims to determine whether the payments should be adjusted for claims containing PPCs.” The State agency added that its contractor had retrospectively processed inpatient hospital claims for our audit period and had identified an estimated recoupment (both Federal and State funds) of almost \$220,000 for claims with PPCs.

We commend the State agency for taking prompt corrective actions in response to our recommendations but note that we did not review the implemented procedures that the State agency outlined to determine their effectiveness.

The State agency’s comments appear in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For our audit period, the State agency claimed \$1,853,574,108 (\$1,155,213,041 Federal share) for inpatient hospital services (footnotes 6 and 7). 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 8) 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 Jefferson City, Missouri, from June 2016 to August 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, and the Missouri 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 MMIS 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 3-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
- discussed the results of our audit with State agency officials on December 19, 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
<i>Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims</i>	<u>A-06-16-08004</u>	3/6/2018
<i>Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-05-15-00033</u>	9/20/16
<i>Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-14-02012</u>	9/15/16
<i>Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-15-02013</u>	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 Missouri 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 13-08, 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.¹¹ 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)).

¹¹ 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 Missouri State plan, effective July 1, 2012, specifies that the State agency's MMIS will flag all claims with diagnoses identified as health-care-acquired conditions for nonpayment. Of these claims, those indicating the diagnosis was "not present on admission" will edit to "Pay But Report" for retrospective clinical review and potential recoupment of inpatient days associated with the health-care-acquired condition.

The MMIS will deny payments for claims in which the POA indicator data field is not filled with a valid POA indicator.



ERIC R. GREITENS, GOVERNOR • STEVE CORSI, Psy.D., DIRECTOR

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April 6, 2018

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

Re: A-07-16-03216

Dear Mr. Cogley:

This letter is in response to the March 14, 2018, Office of Inspector General's (OIG) draft report regarding Missouri's compliance with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain Provider-Preventable Conditions (PPCs) (Report Number: A-07-16-0216). The Department of Social Services' responses to your recommendations are below.

Recommendation: Work with CMS to determine what portion of the \$1,709,925 (Federal share) was unallowable for Federal Medicaid reimbursement and refund that unallowable portion to the Federal Government.

Response: The MO HealthNet Division (MHD) implemented procedures on November 1, 2017 to review all inpatient hospital claims to determine whether the payments should be adjusted for claims containing PPCs.

The MHD's contractor used the 3M All Patients Refined-Diagnosis Related Grouping (APR-DRG) software and health-care acquired conditions (HCAC) logic to retrospectively process inpatient hospital claims from July 1, 2012 through September 30, 2015. Using this software the contractor found 64 paid inpatient claims that were affected by the PPC. The average recoverable HCAC/PPC portion was 34.05% of the claims in question. Therefore the estimated recoupment dollars are \$219,779 (federal and state share).

Interpretive services are available by calling the Participant Services Unit at 1-800-392-2161.
Prevodilačke usluge su dostupne pozivom odjela koji učestvuje u ovom servisu na broj 1-800-392-2161.
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Patrick J. Cogley
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Recommendation: Develop and implement policies and procedures to ensure that all claims with PPCs that have certain present-on-admission (POA) codes are identified and adjusted in accordance with Federal and State requirements.

Response: The MHD's contractor will use the 3M APR-DRG grouper to review all claims with PPCs and identify and adjust claims in accordance with Federal and State requirements.

Recommendation: Enhance system edits to ensure that all claims that lack a valid POA code in the POA indicator data field are denied.

Response: The MHD has edits in place to deny all claims that lack a valid POA indicator. The MHD's contractor will also use the 3M APR-DRG grouper to review all inpatient claims with PPCs and ensure that POA indicators are accurately reported.

Recommendations: Ensure system edits use all of the diagnosis codes that appear on the list of Medicare hospital-acquired conditions when identifying PPCs.

Revise system edits to ensure that the diagnosis codes used for payment reductions include only those codes that are included in the list of Medicare hospital-acquired conditions and that CMS has designated as CCs or MCCs.

Response: The MHD revised its system edits to only include the diagnosis codes that appear on the list of Medicare hospital-acquired conditions.

We concur with the findings with the clarifications above. Please feel free to contact the MHD at (573)751-6944 if you have additional questions.

Sincerely,

/s/

Steve Corsi, Psy. D
Director

SC:JH:bsb

cc: James Scott, CMS