

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ILLINOIS CLAIMED SOME IMPROPER
FEDERAL MEDICAID REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES
RELATED TO TREATING
PROVIDER-PREVENTABLE CONDITIONS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Illinois improperly claimed \$149,000 in Federal Medicaid reimbursement over a 2-year period for inpatient hospital services related to treating certain provider-preventable conditions. In addition, Illinois improperly reduced Federal Medicaid reimbursement by \$52,000 for inpatient hospital services that did not relate to treating provider-preventable conditions.

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 Illinois complied 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 Illinois Department of Healthcare and Family Services (State agency) claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

BACKGROUND

PPCs include two categories of conditions: health-care-acquired conditions (HCAC) and other PPCs. HCACs are conditions occurring in any inpatient hospital setting that: (1) are considered to have a high cost, 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 occurring in any health care setting as identified in a State plan and must include, at a minimum, three specific conditions identified in Federal regulations.

Diagnosis codes that appear on inpatient hospital claims indicate patients' health conditions. Certain diagnosis codes indicate a PPC within a claim.

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 upon the patient's admission 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 HCACs. Federal regulations implementing the ACA, authorize States to identify other PPCs for which Medicaid payments will also be prohibited. Both Federal and State regulations require a reduced payment for a claim by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated.

The Illinois State Plan Amendment effective for hospital admissions between July 1, 2012, and June 30, 2014, authorized the State agency to deduct \$900 per claim payment for inpatient hospital service if a HCAC occurred during the hospital admission.

From July 1, 2012, through June 30, 2014 (audit period), the State agency claimed over \$6 billion (\$3 billion Federal share) for inpatient hospital services.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some inpatient hospital services related to treating certain PPCs.

For our audit period, we identified 584 inpatient hospital claims with Medicaid reimbursements totaling \$37,953,563 (\$18,976,782 Federal share) that contained PPCs and POA codes indicating that either the condition was not present on admission or the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission. Prior to our audit, the State agency did not identify and adjust any claims for inpatient hospital services related to treating PPCs. During our fieldwork, the State agency properly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$106,273 for inpatient hospital services related to treating PPCs billed on 243 of the 584 claims. However, we determined that the State agency improperly claimed on the CMS-64 report Federal Medicaid reimbursement of \$149,198 for inpatient hospital services related to treating PPCs on the remaining 341 claims. The improper reimbursements resulted from claims that the State agency at first properly adjusted but subsequently reversed those adjustments and claims that it failed to adjust.

In addition, the State agency improperly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$51,874 for inpatient hospital services billed on 125 claims that did not contain any PPCs.

The State agency had not developed effective policies and procedures to identify and adjust all claims with PPCs that had certain POA codes in accordance with the Federal and State requirements. During our audit period, the claim processing system utilized by the State agency did not have the capability to identify and adjust claims with PPCs. Consequently, the State agency identified such claims manually using the published State agency's HCAC list that did not match the list of Medicare hospital-acquired conditions (HAC). After our audit period, the State agency implemented the All Patient Refined Diagnosis Related Groups (APR-DRG) system effective July 1, 2014. According to State agency officials, this system has the capability to identify and adjust DRG-reimbursed inpatient hospital claims that contain PPCs. However, the State agency had not implemented any policies and procedures for identifying and adjusting claims with PPCs reimbursed under other methodologies (such as per-diem) on or after July 1, 2014. Because the State agency implemented the APR-DRG system after our audit period, we did not determine whether it was effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government \$149,198 (Federal share) for inpatient hospital services related to treating PPCs that were improperly claimed on the CMS-64 report;
- reprocess claims that did not contain any PPCs but were improperly adjusted and request \$51,874 (Federal share) from the Federal Government;
- ensure that the State agency's list of HCACs matches the list of Medicare HACs;
- strengthen internal controls to ensure that all claims with PPCs that had certain POA codes are identified and adjusted in accordance with the Federal and State requirements; and
- review the inpatient hospital claims it processed and paid after our audit period, and identify for refund to the Federal Government the Federal share of any additional improper payments related to services for treating PPCs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations. The State agency stated that although its HCAC list in effect during the audit period complied with the intent and wording of the approved State Plan, the State agency would refund the improperly claimed Federal share identified in our audit. The State agency also 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 Illinois complied 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 Illinois Department of Healthcare and Family Services (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, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services, administers the Medicaid 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.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. 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, Illinois' FMAP was 50 percent.

Provider-Preventable Conditions

PPCs include two categories of conditions: health-care-acquired conditions (HCAC) and other PPCs. HCAC are conditions occurring in any inpatient hospital setting that (1) are considered to have a high cost, 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)). These conditions include, among others, surgical site infections and foreign objects retained after

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.

surgery. Other PPCs are conditions identified in the State plan. As specified in Federal regulations, the other PPCs, at a minimum, must include: (1) wrong surgical or other invasive procedures performed on a patient, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong patient (42 CFR § 447.26(b)).

Diagnosis codes that appear on inpatient hospital claims indicate patients' health conditions. Certain diagnosis codes² indicate a PPC within a claim.

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 HCACs. Federal regulations implementing the ACA authorize States to identify other PPCs for which Medicaid payments will also be prohibited. Both Federal and State regulations require a reduced payment for a claim by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated. There is no payment reduction for any condition present before admission.

Until June 30, 2014, the State agency utilized a claim processing system that did not have the capability to identify and adjust claims with PPCs. The State agency in cooperation with the

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).

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).

Illinois Hospital Association determined that the average cost increase attributable to a HCAC was \$900 and shared its calculations with CMS.⁵ On June 19, 2014, CMS approved the Illinois State Plan Amendment effective for hospital admissions between July 1, 2012, and June 30, 2014. The State plan authorized the State agency to deduct \$900 per claim payment for any inpatient hospital stay during which the patient acquired any of the HCACs identified by Medicare (other than Deep Vein Thrombosis and Pulmonary Embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients (DVT/PE)).⁶ This requirement applied to all inpatient hospital claims and both the DRG and per-diem claim reimbursement methodologies.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through June 30, 2014 (audit period), the State agency claimed \$6,006,330,017 (\$3,005,268,813 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify claims that contained at least one secondary diagnosis code⁷ 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 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 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.

The Appendix A describes our audit scope and methodology.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some inpatient hospital services related to treating certain PPCs.

For our audit period, we identified 584 inpatient hospital claims with Medicaid reimbursements totaling \$37,953,563 (\$18,976,782 Federal share) that contained PPCs and POA codes indicating that either the condition was not present on admission or the documentation in the patient’s

⁵ Based on the available Medicare data, the formula took into consideration such factors as discharges that had hospital-acquired conditions (HAC), discharges with re-assigned DRGs, and changes in total inpatient hospital claim payments. The average cost increase attributable to HACs for Medicare was \$973. This amount was further reduced to \$900 to account for the difference in Medicare and Medicaid payments.

⁶ The State agency reduced claims at an amount less than \$900 if the total claim payment amount did not exceed \$900.

⁷ We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA’s payment prohibition pertains only to secondary diagnosis codes.

medical record was insufficient to determine whether the condition was present on admission.⁸ Prior to our audit, the State agency did not identify and adjust any claims for inpatient hospital services related to treating PPCs. During our fieldwork, the State agency properly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$106,273 for inpatient hospital services related to treating PPCs billed on 243 of the 584 claims. However, we determined that the State agency improperly claimed on the CMS-64 report Federal Medicaid reimbursement of \$149,198 for inpatient hospital services related to treating PPCs on the remaining 341 claims. The improper reimbursements resulted from claims that the State Agency at first properly adjusted but subsequently reversed those adjustments and claims that it failed to adjust.

In addition, the State agency improperly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$51,874 for inpatient hospital services billed on 125 claims that did not contain any PPCs.

The State agency had not developed effective policies and procedures to identify and adjust all claims with PPCs that had certain POA codes in accordance with the Federal and State requirements. During our audit period, the claim processing system utilized by the State agency did not have the capability to identify and adjust claims with PPCs. Consequently, the State agency identified such claims manually using the published State agency's HCAC list that did not match the list of Medicare hospital-acquired conditions (HAC). After our audit period, the State agency implemented the All Patient Refined Diagnosis Related Groups (APR-DRG) system effective July 1, 2014. According to State agency officials, this system has the capability to identify and adjust DRG-reimbursed inpatient hospital claims that contain PPCs. However, the State agency had not implemented any policies and procedures for identifying and adjusting claims with PPCs that had been reimbursed under other methodologies (such as per-diem) on or after July 1, 2014. Because the APR-DRG system was not implemented until after our audit period, we did not determine whether it was effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

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 and State regulations 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 89 Illinois Administrative Code (IAC) § 148.70(g), effective June 27, 2013, respectively). Further, State regulations provide that each claim that indicated the occurrence of a HCAC would be reduced by \$900 until the APR-DRG system was implemented, and any claim for services related to other PPCs would be denied (89 IAC § 148.70(g)(1) and (3)).

Federal regulations define HCAC as a condition identified as a Medicare HAC, other than DVT/PE (42 CFR § 447.26(b)). Further, "the Secretary has authority to update the Medicare HAC list, as appropriate, and, as such, States are required to comply with subsequent updates or

⁸ None of the claims that we reviewed (1) contained other PPCs or (2) were missing a POA indicator code associated with a PPC.

revisions” (76 Fed. Reg. 32820 (June 6, 2011)). In addition, the definition of other PPCs allows States to expand, based on specific criteria, the conditions identified for non-payment with CMS approval (76 Fed. Reg. 32819 (June 6, 2011)).

In Illinois, hospitals are required to report PPCs using the appropriately designated POA codes for principal and secondary diagnosis codes (89 IAC § 148.70(g)(4)).

The Illinois State Plan Amendment 12-024, Attachment 4.19-A, § XXXIX specifies that the State defines HCACs as HACs identified by Medicare other than DVT/PE. The State determined the following other PPCs for non-payment: wrong surgical procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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

For our audit period, we identified 584 inpatient hospital claims with Medicaid reimbursements totaling \$37,953,563 (\$18,976,782 Federal share) that contained PPCs and POA codes indicating that either the condition was not present on admission or the documentation in the patient’s medical record was insufficient to determine whether the condition was present on admission. Prior to our audit, the State agency did not identify and adjust any claims for inpatient hospital services related to treating PPCs. During our fieldwork, the State agency properly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$106,273 for inpatient hospital services related to treating PPCs billed on 243 of the 584 claims.

The State agency improperly claimed on the CMS-64 report Federal Medicaid reimbursement of \$149,198 for inpatient hospital services related to treating PPCs. The claimed amount represented 341 claims that contained PPCs, consisted of:

- 212 claims for which the State agency failed to reduce the Federal Medicaid reimbursement by \$92,888 for inpatient hospital services related to treating PPCs. The State agency did not reduce the Medicaid reimbursements to the providers by \$185,776 (\$92,888 Federal share) through its claim processing system and, as a result, it did not reduce the Federal Medicaid reimbursement by \$92,888 on the CMS-64 report.
- 128 claims for which the State agency improperly claimed the Federal Medicaid reimbursement of \$55,860 for inpatient hospital services related to treating PPCs. Originally, the State Agency reduced both the Medicaid reimbursements to the providers by \$111,720 (\$55,860 Federal share) through its claim processing system and the Federal Medicaid reimbursement by \$55,860 on the CMS-64 report. Subsequently, the State agency reversed its decision: it refunded the deducted amounts back to the providers and claimed the Federal Medicaid reimbursements of \$55,860 on the CMS-64 report.

- 1 claim for which the State agency failed to reduce the Federal Medicaid reimbursement by \$450 for inpatient hospital services related to treating a PPC. The State agency reduced the Medicaid reimbursement to a provider by \$900 (\$450 Federal share) through its claim processing system; however, it did not reduce the Federal Medicaid reimbursement by \$450 on the CMS-64 report.

Federal and State regulations prohibited the State agency from paying for services related to PPCs as of July 1, 2012. However, the State agency had not developed effective policies and procedures to identify and adjust all claims with PPCs that had certain POA codes in accordance with the Federal and State requirements. During our audit period, the claim processing system utilized by the State agency did not have the capability to identify and adjust claims with PPCs. Consequently, the State agency identified such claims manually using the published State agency's HCAC list⁹ that did not match the list of Medicare HACs.¹⁰ CMS updated its list of Medicare HACs as of October 1, 2012, but the State agency did not update its HCAC list until July 1, 2014. The State agency did not request CMS approval to modify its list of PPCs.

After our audit period, the State agency implemented the APR-DRG system effective July 1, 2014. According to State agency officials, this system has the capability to identify and adjust DRG-reimbursed inpatient hospital claims that contain PPCs. However, the State agency had not implemented any policies and procedures for identifying and adjusting claims with PPCs that had been reimbursed under other methodologies (such as per-diem) on or after July 1, 2014. Because the APR-DRG system was not implemented until after our audit period, we did not determine whether it was effective in prohibiting unallowable payments for inpatient hospital services related to treating PPCs.

THE STATE AGENCY IMPROPERLY REDUCED FEDERAL MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES THAT DID NOT RELATE TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

The State agency improperly reduced the Federal Medicaid reimbursement on the CMS-64 report by \$51,874 for inpatient hospital services billed that did not contain any PPCs. The claimed amount represented 125 claims that did not contain PPCs, consisted of:

- 107 claims for which the State agency improperly reduced both the Medicaid reimbursements to the providers by \$87,547 (\$43,774 Federal share) through its claim processing system and the Federal Medicaid reimbursement by \$43,774 on the CMS-64 report; and

⁹ The Illinois Department of Health and Family Services, "Hospital-Acquired Conditions Effective for Inpatient Admissions on and After July 1, 2012." Available online at http://www.illinois.gov/hfs/SiteCollectionDocuments/07012012_hac.pdf. Accessed on April 28, 2016.

¹⁰ CMS, "FY 2012 Final HAC List." Available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2012_Final_HACsCodeList.pdf. CMS, "FY 2013, FY 2014, and FY 2015 Final HAC List." Available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf. Accessed on April 28, 2016.

- 18 claims for which the State agency properly refunded the originally deducted Medicaid reimbursements of \$16,200 (\$8,100 Federal share) back to the providers through its claim processing system, but it did not increase the Federal Medicaid reimbursement by \$8,100 on the CMS-64 report.

The State agency identified these claims as containing PPCs because the HCAC list it used during our audit period to identify claims that contained services related to treating PPCs did not match the list of Medicare HACs. Also, some claims that contained PPCs were for inpatient hospital services provided prior to July 1, 2012, the effective date of the PPC requirement, and should not have been adjusted.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$149,198 (Federal share) for inpatient hospital services related to treating PPCs that were improperly claimed on the CMS-64 report;
- reprocess claims that did not contain any PPCs but were improperly adjusted and request \$51,874 (Federal share) from the Federal Government;
- ensure that the State agency's list of HCACs matches the list of Medicare HACs;
- strengthen internal controls to ensure that all claims with PPCs that had certain POA codes are identified and adjusted in accordance with the Federal and State requirements; and
- review the inpatient hospital claims it processed and paid after our audit period, and identify for refund to the Federal Government the Federal share of any additional improper payments related to services for treating PPCs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations. The State agency stated that although its HCAC list¹¹ in effect during the audit period complied with the intent and wording of the approved State Plan, the State agency would refund the improperly claimed Federal share identified in our audit. The State agency also provided information on actions that it had taken or planned to take to address our recommendations.

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

¹¹ The State agency refers to HCACs as HACs.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, through June 30, 2014, the State agency claimed \$6,006,330,017 (\$3,005,268,813 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify claims that contained at least one secondary diagnosis code for a PPC and had either (1) a POA code “N” or “U” or (2) the POA code field was blank. A code “N” indicates that the condition was not present on admission and a code “U” indicates that the documentation in the patient’s medical record was insufficient to determine whether the condition was present on admission. None of the claims that we reviewed (1) contained other PPCs or (2) missed a POA indicator code associated with a HCAC.

We did not determine whether the hospitals (1) reported all PPCs, (2) assigned correct diagnosis codes or POA codes, or (3) properly supported their claimed services. We did not assess the adequacy of the State agency’s implementation of any PPC policies and procedures on or after July 1, 2014.

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 May 2015 through April 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials to gain an understanding of inpatient hospital services and the processing of inpatient hospital claims and 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 by the State agency to identify and prevent payment of 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 from July 1, 2012, through June 30, 2014;
- reconciled the inpatient hospital service expenditures claimed by the State agency on the CMS-64 report with supporting schedules and the claim database;

- reviewed the claim database to identify claims with the admission dates between July 1, 2012, and June 30, 2014, that contained PPCs and had the POA codes “N” or “U” or did not have a POA code reported;
- reviewed the claim adjustment file provided by the State agency to determine what claims were identified as containing PPCs and adjusted by the State agency;
- verified with the State agency what PPC adjustments related to the claims in the State agency’s claim adjustment file were reported on the CMS-64 report as of March 30, 2016; 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.

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APPENDIX B: STATE AGENCY COMMENTS

August 4, 2016

Department of Health and Human Services
Office of Audit Services, Region V
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Draft Audit Report A-05-15-00033

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions*".

The Department concurs with the five recommendations given in the draft audit report. The Department is in the process of refunding to hospitals the reductions to claims for hospital acquired conditions (HAC) where the reduction was improperly applied. It is the Department's contention that the HAC list published by the Department was in effect for the time period audited and complies with the intent and wording of the approved state plan. However, the Department will refund the Federal government the Federal share for all claims identified in the audit where the Federal share was improperly claimed. A final review of claims containing HACs will be done in order to identify any claims processed and paid after the audit period to refund the Federal share of any additionally identified improper payments. Lastly, the Department has taken steps to ensure that the State agency's HAC list matches that of Medicare and to strengthen internal controls to ensure all claims with provider preventable conditions that had certain present on admission codes are identified and adjusted in accordance with the Federal and State requirements by implementing a new reimbursement system effective with discharges on or after July 1, 2014. The software for that system is updated annually to remain current with the Medicare list and has the ability to recognize HACs and any associated increase in payment that can be isolated and reduced per the federal requirement.

We appreciate the work completed by your audit team and the open lines of communication with HFS staff throughout this audit. If you have any questions or comments about our response to the audit, please contact Amy Lyons, External Audit Liaison, at (217) 557-0576 or through email at amy.lyons@illinois.gov.

Sincerely,

/Felicia F. Norwood/
Felicia F. Norwood
Director