

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**OKLAHOMA DID NOT HAVE  
PROCEDURES TO IDENTIFY PROVIDER-  
PREVENTABLE CONDITIONS FOR SOME  
INPATIENT HOSPITAL CLAIMS**

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**March 2018  
A-06-16-08004**

# *Office of Inspector General*

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## Report in Brief

Date: March 2018  
Report No. A-06-16-08004

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. PPCs include two categories of conditions: health-care-acquired conditions (HCACs) and Other PPCs.

Federal statute and regulations prohibit Medicaid payments for services related to PPCs. Our objective was to determine whether Oklahoma claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

Oklahoma pays Medicaid inpatient hospital claims using one of these payment methods: diagnosis-related group (DRG) or level of care (LOC).

This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

### How OIG Did This Review

From July 1, 2015, through June 30, 2016, Oklahoma claimed \$118.8 million for Medicaid inpatient hospital services. We analyzed the Medicaid paid claims that contained PPCs.

## Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims

### What OIG Found

Oklahoma appropriately processed and claimed Federal reimbursement for DRG claims with HCACs. However, Oklahoma did not develop procedures to evaluate LOC claims for HCACs. As a result, we could not determine whether it appropriately claimed Federal reimbursement for these LOC claims.

Oklahoma complied with Federal and State requirements by not claiming Federal reimbursement for Other PPCs.

### What OIG Recommends and State Agency Comments

We recommend that Oklahoma develop procedures to evaluate LOC claims for HCACs and determine whether payments should be reduced.

In written comments on our draft report, Oklahoma concurred with our recommendation.

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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.<sup>1</sup> We conducted this review to determine whether Oklahoma was in compliance with the regulations for inpatient hospital services related to treating PPCs. This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.<sup>2</sup>

### OBJECTIVE

Our objective was to determine whether the Oklahoma Health Care Authority (State agency) claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

### BACKGROUND

#### 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. The Federal Government pays its share of a State's medical assistance expenditures according to the Federal medical assistance percentage, which varies depending on each State's relative per-capita income. 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. In Oklahoma, the State agency administers the Medicaid program.

#### Provider-Preventable Conditions

PPCs are certain reasonably-preventable conditions caused by medical accidents or errors in a health care setting. Federal statute and regulations prohibit Federal payments for PPCs.<sup>3</sup> Payment for a claim must be reduced by the amount attributable to the PPC that causes an

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<sup>1</sup> 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.

<sup>2</sup> See Appendix B for a list of the related reports.

<sup>3</sup> The Patient Protection and Affordable Care Act (ACA), 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) and 42 CFR section 447.26.

increase in payment and that can be reasonably isolated. PPCs include two categories of conditions: health-care-acquired conditions (HCACs) and Other PPCs.<sup>4</sup>

### *Health-Care-Acquired Conditions*

HCACs are conditions acquired in a health care setting that (1) are considered to have a high cost or occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented.<sup>5</sup> These conditions include, among others, surgical site infections and foreign objects retained after surgery. These PPCs can be identified on inpatient hospital claims through certain diagnosis codes.<sup>6</sup> Diagnosis codes are used to identify a patient’s health conditions.

An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes.<sup>7</sup> 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**

<b>POA Code</b>	<b>Definition</b>
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

Adhering to Federal regulation and guidance, the Oklahoma State plan and the Oklahoma Administrative Code (OAC) prohibit payment for the portion of a claim attributable to a HCAC with a POA code of “N” or “U” or when the POA code is missing.<sup>8</sup> Payments are not reduced for HCACs with POA codes of “Y” or “W.”

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<sup>4</sup> Before enactment of the ACA and its implementing Federal regulations, HCACs and Other PPCs were referred to as hospital-acquired conditions and “never events,” respectively.

<sup>5</sup> Social Security Act section 1886(d)(4)(D)(iv).

<sup>6</sup> Diagnosis codes are listed in the International Classification of Diseases, which is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.

<sup>7</sup> 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.

<sup>8</sup> State Plan Amendment 10-03, Attachment 4.19-A and OAC section 317-30-3-63(b).

### *Other Provider-Preventable Conditions*

Other PPCs are certain conditions identified in a State plan and must include, at a minimum, one of 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, or a surgical or other invasive procedure performed on the wrong patient.<sup>9</sup> The OAC states that the State agency will not pay for these non-covered procedures.<sup>10</sup>

### **State Agency's Payment Methods for Inpatient Hospital Claims**

The State agency pays Medicaid inpatient hospital claims using one of these payment methods: diagnosis-related group (DRG) or level of care (LOC). Acute-care and critical-access hospitals receive a payment for each inpatient discharge based in part on diagnosis codes that identify a DRG. In contrast, rehabilitative, children's specialty, and Indian Health Services facilities receive a payment based on an LOC per diem rate.

### **HOW WE CONDUCTED THIS REVIEW**

From July 1, 2015, through June 30, 2016, the State agency claimed \$118,772,076 (\$75,305,007 Federal share) for Medicaid inpatient hospital services.<sup>11</sup> We analyzed Medicaid claims that contained at least one secondary diagnosis code for a PPC.<sup>12</sup>

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 contains the details of our audit scope and methodology.

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<sup>9</sup> 42 CFR section 447.26(b).

<sup>10</sup> OAC section 317-30-3-62(b).

<sup>11</sup> 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.

<sup>12</sup> We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA's payment prohibition pertains only to secondary diagnosis codes.

## FINDING

### THE STATE AGENCY DID NOT HAVE PROCEDURES TO IDENTIFY PROVIDER-PREVENTABLE CONDITIONS FOR SOME INPATIENT HOSPITAL CLAIMS

Federal statute and regulations prohibit Federal payments for PPCs.<sup>13</sup> 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.<sup>14</sup> The presence of a PPC on a claim does not always result in an increased payment.<sup>15</sup>

The State agency complied with Federal and State requirements by not claiming Federal reimbursement for Other PPCs. However, HCACs with a POA code of “N,” “U,” or those missing POA codes were present on 47 inpatient hospital claims, totaling \$1,520,227 (\$933,393 Federal share).

The State agency appropriately processed and claimed Federal reimbursement for 29 DRG claims, totaling \$1,126,221 (\$691,855 Federal share). The payments for these claims were either reduced or did not require reduction.

The remaining 18 claims, totaling \$394,006 (\$241,538 Federal share) in payments were LOC claims. Although the State agency required POA codes on all inpatient claims it did not develop procedures to 1) ensure that POA codes were present on LOC claims and 2) determine the applicable amounts to be paid. As a result, we could not determine whether it appropriately claimed Federal reimbursement for these claims.

## RECOMMENDATION

We recommend that the State agency develop procedures to evaluate LOC claims for HCACs and determine whether payments should be reduced.

### STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendation. The State agency’s comments appear as Appendix C. We removed part of the draft report finding in response to the State agency’s comments and redacted comments associated with the part of the finding that we removed.

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<sup>13</sup> ACA section 2702 and 42 CFR section 447.26(a)(1).

<sup>14</sup> 42 CFR section 447.26(c)(3) and OAC section 317-30-3-63(a).

<sup>15</sup> For example, a Medicaid beneficiary with a congenital heart defect developed a post-operative infection after open heart surgery. The nature of this beneficiary’s surgical procedure was so extensive that the HCAC did not trigger a payment increase.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

From July 1, 2015, through June 30, 2016, the State agency claimed \$118,772,076 (\$75,305,007 Federal share) for Medicaid inpatient hospital services (footnote 11). We analyzed the Medicaid claims that contained at least one secondary diagnosis code for a PPC. We did not determine whether the hospitals (1) reported all PPCs, (2) assigned correct diagnosis codes or POA codes, or (3) claimed services that were properly supported.

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

We performed fieldwork at the State agency's office in Oklahoma City, Oklahoma.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the State plan;
- held discussions with State agency officials to gain an understanding of how the State agency identified inpatient hospital services and prevented 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 inpatient hospital claims from the State agency's Medicaid Management Information System that were paid during the audit period;
- reconciled the inpatient hospital service expenditures claimed by the State agency on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, with supporting schedules and the claims database;
- reviewed the claims data to identify claims that contained PPCs;
- selected and tested a sample of inpatient hospital claims with PPCs, including DRG HCACs with POA codes "N" or "U," and LOC HCACs that did not have POA reported; and
- discussed the results of our audit with State agency officials.

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

**APPENDIX B: PREVIOUSLY ISSUED  
OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<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: STATE AGENCY COMMENTS

REBECCA PASTERNIK-IKARD  
CHIEF EXECUTIVE OFFICER



MARY FALLIN  
GOVERNOR

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

December 11, 2017

Mr. Warren Lundy  
Assistant Regional Inspector General for Audit Services  
200 N.W. 4th Street, Suite 4040  
Oklahoma City, OK 73102  
[REDACTED]

**SUBJECT: Report Number A-06-16-08004**

Dear Mr. Warren Lundy:

The Oklahoma Health Care Authority (OHCA) welcomes the opportunity to provide comments on the recommendations contained in the draft report A-06-16-08004 entitled *Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions for Some Inpatient Hospital Claims*. We appreciate the work of the Office of Inspector General (OIG) on this matter.

**Recommendation:** *We recommend that the State agency develop procedures to evaluate LOC [REDACTED] claims for HCACs and determine whether payments should be reduced.*

The OHCA concurs that the agency should develop procedures to evaluate whether LOC claims should be reduced for HCACs. We will work internally and with our partners at CMS to address this issue.

[REDACTED]

Should you have any questions or concerns, please contact Josh Richards, Director of Program Integrity, by telephone at 405-522-7759 or via email at [Josh.Richards@okhca.org](mailto:Josh.Richards@okhca.org).

Respectfully,

[REDACTED]

Rebecca Pasternik-Ikard  
Chief Executive Officer

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**Office of Inspector General Note:** The redacted sections are not applicable because the issue referred to by the State agency is not included in this report