

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEVADA DID NOT COMPLY WITH
FEDERAL AND STATE 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
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Gloria L. Jarmon
Deputy Inspector General
for Audit Services

May 2018
A-09-15-02039

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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.

Report in Brief

Date: May 2018

Report No. A-09-15-02039

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 its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. We conducted this review to determine whether Nevada complied with these regulations for inpatient hospital services. 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 Nevada 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, through June 30, 2014 (audit period), and attempted to identify claims that contained PPCs that were not present on admission. During our fieldwork, we determined that Nevada's paid claim data could not be used because it did not always match the data reported on the actual claims.

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

What OIG Found

Although Federal regulations and the Nevada State plan require Nevada to prohibit, for inpatient hospital services, payment for PPCs that are not present on admission, Nevada's policies and procedures were not adequate to properly identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced. As a result, Nevada may have claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

We attempted to identify claims that contained a PPC and could have been subject to a payment reduction. However, Nevada's paid claim data could not be used to determine whether Nevada claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. As a result, we were not able to determine how many claims contained a PPC or should have had a payment reduction.

What OIG Recommends and Nevada Comments

We recommend that Nevada (1) strengthen its policies and procedures to ensure that it reviews inpatient hospital claims for all Medicare hospital-acquired conditions (i.e., PPCs) identified by CMS and performs retrospective reviews of billing data from all inpatient hospitals to identify PPCs and (2) review retrospective review reports for our audit period and after our audit period to determine whether payments should be reduced for any claims that contain PPCs and refund to the Federal Government its share of any unallowable amounts.

Nevada concurred with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs. 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. We conducted this review to determine whether Nevada 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 Nevada Division of Health Care Financing and Policy (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 June 30, 2014, Nevada's FMAP ranged from 56.2 percent to 90 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 (June 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 Federal regulations 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 (42 CFR § 447.26(c)(3)).

The Nevada State plan (State plan) requires the State agency to meet the Federal requirements related to nonpayment of PPCs and prohibits the State agency from paying for the portion of a claim that is attributable to a PPC. According to the State plan, the State agency reduces payments to providers for inpatient hospital services related to a PPC by an amount attributable to the number of days for treating the PPC.⁶ The State agency may also reduce its payment to a provider for a change to a specific level of care that resulted from a PPC.

Nevada's Procedures for Identifying Provider-Preventable Conditions

The State plan requires the State agency to use prior authorization reviews and retrospective reviews to identify PPCs.

Prior Authorization Reviews

The State agency requires its fiscal agent to review and authorize all inpatient hospital stays before the State agency will reimburse a hospital for services. These prior authorization reviews are required for all inpatient admissions and for any increases in the length of stay or level of care that was initially approved upon admission. The fiscal agent reviews clinical and admission documentation related to each inpatient stay for, among other things, medical necessity and compliance with State agency policy. During these reviews, the fiscal agent will identify services and additional-day requests or level-of-care increases related to treating a PPC.

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 State agency generally reimburses inpatient hospitals for acute care through an all-inclusive, per diem rate by type of admission or service. The all-inclusive rate covers the costs of routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients. The State agency uses nationally accepted standards to determine the number of days attributable to the diagnosis absent the PPC and the incremental number of days attributable to the PPC.

Retrospective Reviews

The State agency contracts with a research center at the University of Nevada, Las Vegas (research contractor), to collect and analyze patient billing data and perform retrospective reviews of these data to identify PPCs. The research contractor collects certain billing data, including POA codes, from the providers. These data are separate from the claim data that the hospitals provide to the State agency for payment.⁷

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through June 30, 2014 (audit period), the State agency claimed \$346,109,392 (\$209,435,165 Federal share) for inpatient hospital services.⁸ We obtained an understanding of the prior authorization and retrospective reviews performed by the State agency's fiscal agent and research contractor. We also reviewed the Medicaid paid claim data for inpatient hospital services and attempted to identify claims that contained PPCs that were not present on admission. During our fieldwork, we determined that the paid claim data provided by the State agency could not be used because the data did not contain all diagnosis codes or procedure codes that were reported on the actual claims, POA codes in the data did not match the POA codes reported on the actual claims, and secondary diagnosis code fields were not populated with only secondary diagnosis codes.

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 did not comply with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs. Although Federal regulations and the State plan require the State agency to prohibit, for inpatient hospital services, payment for PPCs that are not present on admission, the State agency's policies and procedures were not adequate to properly identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced.

⁷ The billing data obtained by the research contractor contain only certain patient identifiers, such as date of birth, date of admission, gender, marital status, and hospital name, and do not contain a unique identifier, such as a claim number, that corresponds to a paid claim within the State agency's Medicaid Management Information System (MMIS).

⁸ The audit period encompassed the most current data available at the time we initiated our review.

As a result, the State agency may have claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

We attempted to identify claims that contained a PPC and could have been subject to a payment reduction. However, the State agency's paid claim data could not be used to determine whether the State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. As a result, we were not able to determine how many claims contained a PPC or should have had a payment reduction.

FEDERAL AND STATE REQUIREMENTS

The ACA and Federal regulations prohibit Federal payments for health-care-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Federal regulations state that payment is not denied for an entire claim that contains a PPC; instead, the regulations 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)).

Each State agency must identify for nonpayment the conditions on the list of Medicare hospital-acquired conditions and is required to comply with subsequent updates or revisions to the list (76 Fed. Reg. 32816, 32820 (June 6, 2011)). 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 complications or comorbidities (CCs) or major CCs (MCCs) are considered Medicare hospital-acquired conditions (76 Fed. Reg. 25789, 25810 (May 5, 2011)).⁹

Under the State plan, the fiscal agent will screen prior authorizations and deny payment for continued-stay requests or increases to the level of care that relate to the treatment of PPCs. The State plan also requires the research contractor to perform a retrospective review of patient billing data, and providers are supplied information identifying claims that have potential PPCs. Provider-confirmed PPCs are subject to payment adjustment (State Plan Amendment 12-005, Attachment 4.19-A).

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 comply with Federal and State requirements prohibiting Medicaid payment for inpatient hospital services related to treating certain PPCs. Specifically, the State agency did not properly identify PPCs on claims for inpatient hospital services and did not determine whether payments for claims containing PPCs should have been reduced.

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

The State Agency Did Not Properly Identify Provider-Preventable Conditions on Claims for Inpatient Hospital Services

The State agency did not properly identify PPCs on claims for inpatient hospital services because it did not use the updated list of Medicare hospital-acquired conditions, correctly identify PPC diagnosis codes on that list, or perform retrospective reviews of all hospitals' inpatient billing data.

The State Agency Did Not Use the Updated List of Medicare Hospital-Acquired Conditions

For prior authorization reviews of services performed on or after October 1, 2012, the State agency's fiscal agent did not use the list of Medicare hospital-acquired conditions that was effective October 1, 2012. At that time, CMS expanded the list of Medicare hospital-acquired conditions to include more diagnosis codes and diagnosis code/procedure code combinations.¹⁰ By using an outdated list, the State agency was not able to identify those PPCs that were added as of October 1, 2012.

The State Agency Incorrectly Identified Some Patients' Health Conditions as Provider-Preventable Conditions

To identify PPCs during prior authorization reviews, the fiscal agent reviewed the hospital's clinical and admission documentation to determine whether a patient's health condition fell within any of the 14 categories of Medicare hospital-acquired conditions. When a condition was found to be within one of these categories, the fiscal agent consulted the list of Medicare hospital-acquired conditions to determine whether any diagnosis codes on that list matched the diagnosis codes shown in the hospital's documentation. However, the State agency did not properly identify as PPCs only those diagnosis codes that were defined as CCs or MCCs within the ranges of diagnosis codes that CMS identified in the list of Medicare hospital-acquired conditions.

According to a fiscal agent official, any diagnosis code within a range of diagnosis codes in the list of Medicare hospital-acquired conditions was considered a PPC because the State agency did not instruct the fiscal agent to identify as PPCs only the diagnosis codes that were defined as CCs or MCCs. As a result, the State agency could have potentially identified some patients' health conditions as PPCs and improperly reduced the related payment amounts.

¹⁰ The list of Medicare hospital-acquired conditions for the year that ended September 30, 2012, included 1,081 diagnosis codes and 94 diagnosis code/procedure code combinations, and the list that was effective October 1, 2012, through September 30, 2015, included 1,083 diagnosis codes and 137 diagnosis code/procedure code combinations.

The State Agency Did Not Perform Retrospective Reviews of All Inpatient Hospitals

To identify PPCs during retrospective reviews, the research contractor analyzed the billing data, including POA codes. However, according to the State agency, it did not require all inpatient hospitals to provide POA codes to the research contractor. Because these codes were not available, the research contractor was not able to perform retrospective reviews of these providers.

The State Agency Did Not Determine Whether Payments for Claims Containing Provider-Preventable Conditions Should Have Been Reduced

For those inpatient hospitals that did submit POA codes to the research contractor, the State agency did not determine whether payments for claims containing PPCs should have been reduced. In May 2014, the research contractor provided to the State agency a report for fiscal year (FY) 2013 identifying inpatient hospital services that may have been related to treating PPCs. However, according to the State agency, it never reviewed the report to determine whether any of the payments associated with those services should have been reduced.

In November 2016, the research contractor provided to the State agency an updated report of potential PPCs related to services provided from FYs 2012 through 2015.¹¹ Because only certain patient identifiers were obtained by the research contractor and included in the report, the State agency could not readily identify corresponding claims for all the inpatient services in the report without requesting additional information from providers.

During May and June 2017, the State agency contacted providers directly and requested documentation regarding the potential PPCs. As of August 2017, the State agency was gathering the documents and had not reduced payment on any claims.

THE STATE AGENCY'S POLICIES AND PROCEDURES WERE NOT ADEQUATE

The State agency's policies and procedures were not adequate to properly identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced:

- The policies and procedures for prior authorization reviews required the fiscal agent to use an outdated list of Medicare hospital-acquired conditions that excluded some PPCs and did not properly identify CCs or MCCs within the ranges of diagnosis codes from the list.
- The State agency did not have specific policies and procedures for the research contractor to conduct the retrospective reviews, so they were not performed on all inpatient hospitals.

¹¹ For our audit period, the research contractor identified 102 inpatient hospital services with potential PPCs.

- The State agency did not have policies and procedures to review potential PPCs identified by the research contractor to determine whether any of the payments associated with those services should have been reduced. State agency officials told us that they thought the number of potential PPCs was low and that they did not have the resources necessary to follow up on potential PPCs that the research contractor identified.

During our audit, the State agency was in the process of developing new policies and procedures for PPCs. However, because these policies and procedures were not implemented before our audit was completed, we did not determine whether they would be effective in prohibiting payments for inpatient hospital services related to treating certain PPCs.

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

The State agency may have claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. To determine whether the State agency claimed Federal Medicaid reimbursement for these services, we attempted to identify claims that contained a PPC and could have been subject to a payment reduction. However, the State agency's paid claim data could not be used to determine whether the State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. Specifically, the State agency's data did not contain all diagnosis codes or procedure codes that were reported on the actual claims, POA codes in the data did not match the POA codes reported on the actual claims, and secondary diagnosis code fields were not populated with only secondary diagnosis codes. As a result, we were not able to determine how many claims contained a PPC or should have had a payment reduction.

RECOMMENDATIONS

We recommend that the State agency:

- strengthen its policies and procedures to ensure that it:
 - reviews inpatient hospital claims for all Medicare hospital-acquired conditions identified by CMS and
 - performs retrospective reviews of billing data from all inpatient hospitals to identify PPCs and
- review retrospective review reports for our audit period and after our audit period to determine whether payments should be reduced for any claims that contain PPCs and refund to the Federal Government its share of any unallowable amounts.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. The State agency also provided with its comments an attachment containing updated procedures for its fiscal agent to use to identify PPCs during prior authorization reviews. The State agency's comments are included in their entirety as Appendix C. However, we did not include the attachment because it contained confidential information.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, through June 30, 2014, the State agency claimed \$346,109,392 (\$209,435,165 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services and attempted to identify 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 (“N”), (2) had a POA code indicating the documentation in the patient’s medical record was insufficient to determine whether the condition was present on admission (“U”), or (3) did not have a POA code reported (i.e., the POA code was missing). We did not determine whether the hospitals reported all PPCs, assigned correct diagnosis codes or POA codes, or claimed services that were properly supported.

During our fieldwork, we determined that the paid claim data provided by the State agency could not be used to determine whether the State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. Specifically, the State agency’s data did not contain all diagnosis codes or procedure codes that were reported on the actual claims, POA codes in the data did not match the POA codes reported on the actual claims, and secondary diagnosis code fields were not populated with only secondary diagnosis codes.¹² We attempted to reconcile paid claims from the data with inpatient hospital services identified on the retrospective review reports provided by the research contractor; however, because only certain patient identifiers were included in the reports, we were unable to identify corresponding paid claims.

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 September 2015 through March 2017 and performed fieldwork at the State agency’s office in Carson City, Nevada.

METHODOLOGY

To accomplish our objective, we:

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

¹² The secondary diagnosis code field was sometimes populated with the external-cause-of-injury diagnosis code, admitting diagnosis code, or principal diagnosis code.

- held discussions with State agency officials, the fiscal agent, and the research contractor to gain an understanding of inpatient hospital services and PPCs and any action taken (or planned) 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 claim databases containing inpatient hospital service expenditures from the State agency’s MMIS for claims paid during our 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 databases;
- reviewed the paid claim data and attempted to identify claims that contained PPCs and had the POA codes “N” or “U” or did not have a POA code reported;
- tested the accuracy and reliability of the paid claim data by comparing a sample of actual claims submitted by providers with the paid claim data;
- attempted to reconcile paid claims from the MMIS with inpatient hospital services identified on the retrospective review reports provided by the research contractor; 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-07-17-03221</u>	5/14/2018
<i>Missouri Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-07-16-03216</u>	5/14/2018
<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>	9/20/2016
<i>Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-14-02012</u>	9/15/2016
<i>Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-15-02013</u>	9/15/2016

APPENDIX C: STATE AGENCY COMMENTS

BRIAN SANDOVAL
Governor



RICHARD WHITLEY, MS
Director

MARTA JENSEN
Administrator

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April 25, 2018

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 Seventh Street, Suite 3-650
San Francisco, CA 94103

Re: Report Number A-09-15-02039

Dear Ms. Ahlstrand,

Thank you for the opportunity to provide feedback on the draft report titled "*Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions*". Below are our written comments in response to this report:

Recommendation 1: Strengthens its policies and procedures to ensure that it:

- a. reviews inpatient hospital claims for all Medicare hospital-acquired conditions identified by CMS;

Response: The State concurs with this recommendation. The State has revised the direction to the Agency's fiscal agent (see attachment A) to ensure that they are conducting their screening of prior authorization requests using the most up-to-date Medicare HAC list. This change was effective on October 20, 2016.

- b. performs retrospective reviews of billing data from all inpatient hospitals to identify PPCs; and

Response: The State concurs with this recommendation. The State is in the process of MMIS modernization with an anticipated go-live date in the first quarter of 2019. The new system will contain and make accessible all diagnosis and Present On Admission (POA) codes submitted on the claim, allowing the State to conduct timely retrospective reviews of inpatient hospital paid claims.

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Recommendation 2: Review retrospective review reports for our audit period and after our audit period to determine whether payments should be reduced for any claims that contain PPCs and refund to the Federal Government its share of unallowable amounts.

Response: The State concurs with this recommendation. The State is in the process of conducting retrospective reviews of all potential PPCs identified by the research contractor for the period of FFY 2012 - 2016. This period includes the audit period of this report. All confirmed PPCs will be evaluated to determine whether a claim was paid for which payment should be reduced. The State will refund to the Federal Government its share of unallowable amounts. Hereafter, the State will conduct this review on an annual basis after receiving the report from the research contractor.

If you have further questions or concerns, please contact Cody Phinney, Deputy Administrator at (775) 684-3735 or via email at cphinney@dncfp.nv.gov.

Sincerely,



Marta Jensen
Administrator

Cc: Richard Whitley, Director, Department of Health and Human Services (DHHS)
Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy

*Nevada Department of Health and Human Services
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