

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LOUISIANA 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

December 2018
A-06-16-02003

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: December 2018

Report No. A-06-16-02003

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. 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 Louisiana 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 and the noncovered days for inpatient hospital claims from January 1, 2013, through June 30, 2017, to identify claims that contained at least one secondary diagnosis code for a PPC and those missing a present on admission (POA) code, or with a POA indicating that the condition was either not present on admission or the documentation in the medical record was insufficient to make a determination.

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

What OIG Found

Louisiana did not comply with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs because it did not have controls to identify claims with PPCs that would have required a reduction in claim payment. Specifically, Louisiana did not (1) ensure hospitals were submitting the days associated with services related to PPCs as noncovered days, (2) conduct postpayment reviews for PPCs, and (3) identify claims with missing POA codes.

We identified inpatient hospital claims totaling \$55.4 million (\$34.9 million Federal share) that contained a diagnosis code identified as a PPC and certain POA codes, or the claims were missing POA codes.

What OIG Recommends

We recommend that Louisiana (1) work with CMS to determine what portion of the \$34.9 million Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount; (2) review all claims before our audit period (with dates of admission from July 1, 2012, and paid through December 31, 2012), and all claims paid after our audit period (June 30, 2017), to determine whether payments should be reduced for any claims that contained PPCs, refunding to the Federal Government its share of any unallowable amounts; and (3) strengthen its internal controls to ensure hospitals submit services related to PPCs as noncovered days, postpayment reviews are conducted, and POA codes are submitted on claims.

Louisiana agreed with our recommendations and described actions it will take to address them.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review	1
Objective	1
Background	1
The Medicaid Program.....	1
Provider-Preventable Conditions.....	1
Diagnosis Codes and Present-on-Admission Codes.....	2
Prohibition of Payment for Provider-Preventable Conditions	3
How We Conducted This Review	3
FINDINGS.....	4
Federal and State Requirements	4
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.....	5
RECOMMENDATIONS	6
STATE AGENCY COMMENTS	7
APPENDICES	
A: Audit Scope and Methodology	8
B: Related Office of Inspector General Reports.....	10
C: State Agency Comments.....	11

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 Louisiana 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 Louisiana Department of Health (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 January 1, 2013, through June 30, 2017 (audit period), Louisiana's FMAP ranged from 62.05 percent to 96.60 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 versions of the ICD was the 9th and 10th Revisions, 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 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)).

State regulations prohibit Medicaid program reimbursement for PPCs, effective for dates of service on or after July 1, 2012 (Louisiana Administrative Code (LAC) Title 50, Part V, § 109(A)). Further, for discharges on or after July 1, 2012, all hospitals are required to bill the appropriate POA code for each diagnosis code billed, and all claims with a POA code with a health-care-acquired condition not present on admission will be denied payment (LAC Title 50, Part V, § 109(D)).

The Louisiana 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, for per diem payments, 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.

The State agency's Hospital Services Provider Manual (provider manual) requires the hospitals to identify the additional days attributable to PPCs and report them as noncovered days on a separate claim form utilizing bill type code 110. Bill type code 110 is designated for inpatient hospital service claims that are not to be paid. The State agency's Medicaid Payment Policy and Billing Instructions regarding PPCs state that payments may be disallowed or reduced based on a postpayment review of the medical record and that POA codes are required for all diagnosis codes. In July 2012, the State agency implemented a system edit to deny claims that have a bill type code 110.

HOW WE CONDUCTED THIS REVIEW

During our audit period, the State agency claimed \$1.356 billion (\$857 million Federal share) for inpatient hospital services.⁶ We reviewed the Medicaid paid claim data for inpatient hospital

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 Medicare crossover claims were not included in our review.

services to identify claims that contained at least one secondary diagnosis code⁷ for a PPC and that (1) had POA code "N," (2) had POA code "U," or (3) did not have a POA code reported. We also reviewed claim data for noncovered days (i.e., claims designated as bill type code 110) to determine whether hospitals properly submitted claims identified as PPCs. In addition, we conducted site visits and interviewed officials at two hospitals to determine whether they had procedures to identify and report PPCs.

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 PPCs. For our audit period, we identified 4,125 paid claims totaling \$55,434,081 (\$34,939,072 Federal share) that contained PPCs and (1) POA code "N," (2) POA code "U," or (3) no POA code.

Although Federal and State regulations and the State plan required the State agency to prohibit, for inpatient hospital services, payment for PPCs that are not present on admission, the State agency did not have adequate internal controls to determine whether payments should have been reduced for claims that contained PPCs. As a result, the State agency did not determine the unallowable portion of the \$55,434,081 (\$34,939,072 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by CMS and the State agency.

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 and the State plan do not deny payment for an entire claim that contains a PPC; instead, the requirements limit the reduction of the payment to the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and State Plan Amendment 12-10, Attachment 4.19-A, respectively).

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

State regulations prohibit Medicaid program reimbursement for PPCs for dates of service on or after July 1, 2012 (LAC Title 50, Part V, § 109(A)). For discharges on or after July 1, 2012, all hospitals are required to bill the appropriate POA code for each diagnosis code billed, and all claims with a health care-acquired condition code will be denied payment (LAC Title 50, Part V, § 109(D)).

The State plan requires the State agency to meet the Federal requirements related to nonpayment of PPCs, and effective July 1, 2012, reimbursement for services shall be based on the PPC policy defined in 42 CFR § 447.26. The State plan requires the number of days covered to be reduced by the number of days associated with the PPC, and no reduction in payment for PPCs will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment.

The provider manual requires the hospitals to identify the additional days attributable to PPCs and report them as noncovered days on a separate claim form utilizing bill type code 110. The provider manual also states that payments may be disallowed or reduced based on a postpayment review of the medical record and that POA codes are required for all diagnosis codes.

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 claimed \$55,434,081 (\$34,939,072 Federal share) for Medicaid inpatient hospital services related to treating certain PPCs. The claimed amount represented 4,125 claims that contained PPCs, consisting of:

- 45 claims that had a POA code of “N” or “U” and
- 4,080 claims that did not have a POA code for the PPC diagnosis code(s).⁸

The State agency did not comply with the requirements prohibiting Medicaid payment for treatment of PPCs because it did not have adequate internal controls to determine whether payments should have been reduced for claims that contained PPCs. Specifically, the State agency did not (1) ensure hospitals were submitting the days associated with services related to PPCs as noncovered days, (2) conduct postpayment reviews for PPCs, and (3) identify claims with missing POA codes.⁹

⁸ Of the 4,080 claims, 169 of them contained a POA code of “1,” which CMS considers as an equivalent to blank.

⁹ The electronic claim form utilized by hospitals in Louisiana includes fields for 1 primary and up to 25 secondary diagnosis and POA codes. From 2011 through 2016, the State agency captured POA codes for as many as five

Although the State agency required hospitals to submit days for PPCs utilizing bill type code 110, and the State agency's system denied claims with bill type code 110, none of the hospitals' claims for noncovered days included a PPC. Our discussions with officials at two hospitals confirmed that they reviewed the accuracy of the diagnosis and POA codes on their claims, but neither hospital used a bill type code 110 to submit any claims that had PPCs.

In addition, the provider manual indicated that payment for a claim containing a PPC may be disallowed or reduced based on a postpayment review of the medical records. However, according to discussion with State agency staff, the State agency did not conduct postpayment reviews for PPCs and had not reduced payment for any claims that contained PPCs. The provider manual also required hospitals to submit POA codes, but the State agency did not have procedures to ensure POA codes were submitted on claims.

Because the State agency did not have adequate internal controls, the State agency did not determine the unallowable portion of the \$55,434,081 (\$34,939,072 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by CMS and the State agency.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the \$34,939,072 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount;
- review all claims with dates of admission before our audit period (from July 1, 2012, and paid through December 31, 2012), and all claims paid after our audit period (June 30, 2017), to determine whether payments should be reduced for any claims that contained PPCs and refund to the Federal Government its share of any unallowable amounts; and
- strengthen its internal controls to ensure:
 - hospitals submit services related to PPCs using bill type code 110,
 - postpayment reviews for PPCs are conducted, and
 - POA codes are submitted on claims.

secondary diagnosis codes. In 2016 and 2017, the State agency increased the number of POA codes captured to 8 and 12, respectively.

STATE AGENCY COMMENTS

The State agency agreed with our recommendations and described actions it will take to address them. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1, 2013, through June 30, 2017, the State agency claimed \$1.356 billion (\$857 million Federal share) for inpatient hospital services (see footnote 6). We reviewed the Medicaid paid claims to identify claims that contained at least one secondary diagnosis code for a PPC and that (1) had POA code “N,” (2) had POA code “U,” or (3) did not have a POA code reported (i.e., the POA code was missing). We also reviewed claim data for noncovered days (i.e. claims designated as bill type code 110) to determine whether hospitals properly submitted claims identified as PPCs. 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 conducted site visits and interviewed officials at two separate hospitals to determine whether they had procedures to identify and report PPCs.

We attempted to identify missing POA codes from the original claims submitted by the hospitals and match those codes to the claims that were processed and paid through the State agency’s Medicaid Management Information System (MMIS).¹⁰ However, the State agency was not able to provide us a reliable connection (as the connection is typically made during automated processing) between the claim submitted by the hospital and the claim that was processed and eventually paid by the State agency. As a result, we were not able to eliminate claims where the hospital may have provided POA codes of “Y” or “W” on the original claim, but the paid claim data showed the POA code missing.

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 March 2017 through May 2018 and performed fieldwork at the State agency’s office in Baton Rouge, Louisiana.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws and guidance, the Louisiana State plan, and the State agency’s hospital provider manual and Medicaid payment policy and billing instructions regarding PPCs;

¹⁰ Although the State agency’s MMIS did not capture all POA codes submitted by the hospitals, the State agency retained, in a separate claim history file, all complete claims submitted by the hospitals, which included all POA codes and diagnosis codes the hospital reported.

- 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;
- held discussions with State agency officials and the fiscal agent 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 paid claims and claims for noncovered days 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 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 identify the missing POA codes from the original claims submitted by the hospitals to be paid and match those POA codes to the claims that were processed and paid through the State agency’s MMIS;
- interviewed officials at two hospitals to determine whether they were submitting claims for noncovered services utilizing bill type code 110; 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>Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-09-15-02039</u>	5/29/2018
<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>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>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

John Bel Edwards
GOVERNOR



Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana Louisiana Department of Health Office of Management and Finance

November 30, 2018

Patricia Wheeler
Regional Inspector General for Audit Services
Department of Health and Human Services, Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, Texas 75242

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

Dear Ms. Wheeler:

Thank you for the opportunity to respond to the findings of your audit on LDH's compliance with federal and state regulations related to provider-preventable conditions (PPCs). The Bureau of Health Services Financing (BHSF), which is responsible for administration of the Medicaid program in Louisiana, is committed to ensuring compliance with federal and state regulations for inpatient hospital services and prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs.

We have reviewed the audit findings and provide the following response to the recommendations documented in the report.

Recommendation 1: Work with CMS to determine what portion of the \$34,939,072 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount.

LDH Response: LDH agrees with this recommendation. LDH will work with CMS to determine what portion of the Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal government the unallowable amount.

Recommendation 2: Review all claims with dates of admission before our audit period (from July 1, 2012, and paid through December 31, 2012), and all claims paid after our audit period (June 30, 2017), to determine whether payments should be reduced for any claims that contained PPCs and refund to the Federal Government its share of any unallowable amounts.

Ms. Patricia Wheeler
November 30, 2018
Page 2

LDH Response: LDH agrees with this recommendation. LDH will review the claims for the period in question to determine whether payments should be reduced for any claims or Federal share refunded for unallowable amounts.

Recommendation 3: Strengthen its internal controls to ensure:

- hospitals submit services related to PPCs using bill type code 110,
- post-payment reviews for PPCs are conducted, and
- POA codes are submitted on claims.

LDH Response: LDH agrees with this recommendation. The Hospital Services Provider Manual requires that hospitals submit services related to PPCs using bill type code 110 and that POA codes are submitted on claims. LDH will evaluate its claims edits related to PPCs to ensure that PPCs are appropriately denied for payment.

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342-0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,



Cindy Rives
Undersecretary

CR/mb