RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Medicaid Program

Permanent Rule Only

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) July 1, 2013 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: To establish the Agency's payment policy for services provided to clients on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) by health care professionals and inpatient hospitals that result in provider preventable conditions (PPCs).

Citation of existing rules affected by this order:

Repealed:
Amended: 182-550-1650
Suspended:

Statutory authority for adoption: 42 CFR § 447.26

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 13-08-058 on March 29, 2013.

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:

phone ( ) _____
fax ( ) _____
e-mail _____

Date adopted:

May 14, 2013

NAME (TYPE OR PRINT)
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TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 14, 2013
TIME: 4:44 PM

WSR 13-11-051

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	

The number of sections adopted at the request of a nongovernmental entity:

New _____ Amended _____ Repealed _____

The number of sections adopted in the agency's own initiative:

New _____ Amended _____ Repealed _____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New 1 Amended 1 Repealed _____

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	1	Amended	1	Repealed	

NEW SECTION

WAC 182-502-0022 Provider preventable conditions (PPCs)--Payment policy. (1) This section establishes the agency's payment policy for services provided to medicaid clients on a fee-for-service basis or to a client enrolled in a managed care organization (defined in WAC 182-538-050) by health care professionals and inpatient hospitals that result in provider preventable conditions (PPCs).

(2) The rules in this section apply to:

(a) All health care professionals who bill the agency directly; and

(b) Inpatient hospitals.

(3) Definitions. The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) **Agency -** See WAC 182-500-0010.

(b) **Health care-acquired conditions (HCAC) -** A condition occurring in any inpatient hospital setting (identified as a hospital acquired condition by medicare other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(c) **Other provider preventable conditions (OPPC) -** The list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 and published by the National Quality Forum.

(d) **Present on admission (POA) indicator -** A status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(e) **Provider preventable condition (PPC) -** An umbrella term for hospital and nonhospital acquired conditions identified by the agency for nonpayment to ensure the high quality of medicaid services. PPCs include two distinct categories: Health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

(4) **Health care-acquired condition (HCAC) -** The agency will deny or recover payment to health care professionals and inpatient hospitals for care related only to the treatment of the consequences of a HCAC.

(a) HCAC conditions include:

(i) Foreign object retained after surgery;

(ii) Air embolism;

(iii) Blood incompatibility;

(iv) Stage III and IV pressure ulcers;

(v) Falls and trauma:
(A) Fractures;
(B) Dislocations;
(C) Intracranial injuries;
(D) Crushing injuries;
(E) Burns;
(F) Other injuries.
(vi) Manifestations of poor glycemic control:
(A) Diabetic ketoacidosis;
(B) Nonketotic hyperosmolar coma;
(C) Hypoglycemic coma;
(D) Secondary diabetes with ketoacidosis;
(E) Secondary diabetes with hyperosmolarity.
(vii) Catheter-associated urinary tract infection (UTI);
(viii) Vascular catheter-associated infection;
(ix) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG);
(x) Surgical site infection following bariatric surgery for obesity:
(A) Laparoscopic gastric bypass;
(B) Gastroenterostomy; or
(C) Laparoscopic gastric restrictive surgery.
(xi) Surgical site infection following certain orthopedic procedures:
(A) Spine;
(B) Neck;
(C) Shoulder;
(D) Elbow.
(xii) Surgical site infection following cardiac implantable electronic device (CIED).
(xiii) Deep vein thrombosis/pulmonary embolism (DVT/PE) following certain orthopedic procedures:
(A) Total knee replacement; or
(B) Hip replacement.
(xiv) Latrogenic pneumothorax with venous catheterization.
(b) Hospitals must include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator is to be used according to the official coding guidelines for coding and reporting and the CMS guidelines. The POA indicator may prompt a review, by the agency or the agency's designee, of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines. The agency will identify professional claims using the information provided on the hospital claims.
(c) HCACs are based on current medicare inpatient prospective payment system rules with the inclusion of POA indicators. Health care professionals and inpatient hospitals must report HCACs on claims submitted to the agency for consideration of payment.
(5) **Other provider preventable condition (OPPC) -** The agency will deny or recoup payment to health care professionals and inpatient hospitals for care related only to the treatment of consequences of an OPPC when the condition:
(a) Could have reasonably been prevented through the

application of nationally recognized evidence based guidelines;

(b) Is within the control of the hospital;

(c) Occurred during an inpatient hospital admission;

(d) Has a negative consequence for the beneficiary;

(e) Is auditable; and

(f) Is included on the list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 effective on the date the incident occurred. The list of serious reportable events in health care, as of the publishing of this rule, includes:

(i) Surgical or invasive procedure events:

(A) Surgical or other invasive procedure performed on the wrong site;

(B) Surgical or other invasive procedure performed on the wrong patient;

(C) Wrong surgical or other invasive procedure performed on a patient;

(D) Unintended retention of a foreign object in a patient after surgery or other invasive procedure;

(E) Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

(ii) Product or device events:

(A) Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the hospital;

(B) Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;

(C) Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a hospital.

(iii) Patient protection events:

(A) Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person;

(B) Patient death or serious injury associated with patient elopement;

(C) Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a hospital.

(iv) Care management events:

(A) Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);

(B) Patient death or serious injury associated with unsafe administration of blood products;

(C) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a hospital;

(D) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

(E) Patient death or serious injury associated with a fall while being cared for in a hospital;

(F) Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a hospital (not present on

admission);

(G) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;

(H) Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results.

(v) Environmental events:

(A) Patient death or serious injury associated with an electric shock in the course of a patient care process in a hospital;

(B) Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances;

(C) Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a hospital;

(D) Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a hospital.

(vi) Radiologic events: Death or serious injury of a patient associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area.

(vii) Potential criminal event:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(B) Abduction of a patient of any age;

(C) Sexual abuse/assault on a patient within or on the grounds of a health care setting;

(D) Death or serious injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting.

(6) Reporting PPCs.

(a) The agency requires inpatient hospitals to report PPCs (as appropriate according to (d) and (e) of this subsection) to the agency by using designated present on admission (POA) indicator codes and appropriate HCPCs modifiers that are associated:

(i) With claims for medical assistance payment; or

(ii) With courses of treatment furnished to clients for which medical assistance payment would otherwise be available.

(b) Health care professionals and inpatient hospitals must report PPCs associated with medicaid clients to the agency even if the provider does not intend to bill the agency.

(c) Use of the appropriate POA indicator codes informs the agency of the following:

(i) A condition was present at the time of inpatient hospital admission or at the time the client was first seen by the health care professional or hospital; or

(ii) A condition occurred during admission or encounter with a health care professional either inpatient or outpatient.

(d) Hospitals must notify the agency of an OPPC associated with an established medicaid client within forty-five calendar days of the confirmed OPPC in accordance with RCW 70.56.020. If the

client's medicaid eligibility status is not known or established at the time the OPPC is confirmed, the agency allows hospitals thirty days to notify the agency once the client's eligibility is established or known.

(i) Notification must be in writing, addressed to the agency's chief medical officer, and include the OPPC, date of service, client identifier, and the claim number if the facility submits a claim to the agency.

(ii) Hospitals must complete the appropriate portion of the HCA 12-200 form to notify the agency of the OPPC. Agency forms are available for download at: http://maa.dshs.wa.gov/forms/.

(e) Health care professionals or designees responsible for or may have been associated with the occurrence of a PPC involving a medicaid client must notify the agency within forty-five calendar days of the confirmed PPC in accordance with chapter 70.56 RCW. Notifications must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, and client identifier. Providers must complete the appropriate portion of the HCA 12-200 form to notify the agency of the PPC. Agency forms are available for download at http://maa.dshs.wa.gov/forms/.

(f) Failure to report, code, bill or claim PPCs according to the requirements in this section will result in loss or denial of payments.

(7) Identifying PPCs. The agency may identify PPCs as follows:

(a) Through the department of health (DOH); or

(b) Through the agency's program integrity efforts, including:

(i) The agency's claims payment system;

(ii) Retrospective hospital utilization review process (see WAC 182-550-1700);

(iii) The agency's provider payment review process (see WAC 182-502-0230);

(iv) The agency's provider audit process (see chapter 182-502A WAC); and

(v) A provider or client complaint.

(8) Payment adjustment for PPCs. The agency or its designee conducts a review of the PPC prior to reducing or denying payment.

(a) The agency does not reduce, recoup, or deny payment to a provider for a PPC when the condition:

(i) Existed prior to the initiation of treatment for that client by that provider. Documentation must be kept in the client's clinical record to clearly support that the PPC existed prior to initiation of treatment; or

(ii) Is directly attributable to a comorbid condition(s).

(b) The agency reduces payment to a provider when the following applies:

(i) The identified PPC would otherwise result in an increase in payment; and

(ii) The portion of the professional services payment directly related to the PPC, or treatment of the PPC, can be reasonably isolated for nonpayment.

(c) The agency does not make additional payments for services on claims for covered health care services that are attributable to

HCACs and/or are coded with POA indicator codes "N" or "U."

(d) Medicare crossover claims. The agency applies the following rules for these claims:

(i) If medicare denies payment for a claim at a higher rate for the increased costs of care under its PPC policies:

(A) The agency limits payment to the maximum allowed by medicare;

(B) The agency does not pay for care considered nonallowable by medicare; and

(C) The client cannot be held liable for payment.

(ii) If medicare denies payment for a claim under its national coverage determination agency from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(A) The agency does not pay the claim, any medicare deductible or any coinsurance related to the inpatient hospital and health care professional services; and

(B) The client cannot be held liable for payment.

(9) The agency will calculate its reduction, denial or recoupment of payment based on the facts of each OPPC or HCAC. Any overpayment applies only to the health care professional or hospital where the OPPC or HCAC occurred and does not apply to care provided by other health care professionals and inpatient hospitals, should the client subsequently be transferred or admitted to another hospital for needed care.

(10) Medicaid clients are not liable for payment of an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the agency, and must not be billed for any item or service related to a PPC.

(11) Provider dispute process for PPCs.

(a) A health care professional or inpatient hospital may dispute the agency's reduction, denial or recoupment of payment related to a PPC as described in chapter 182-502A WAC.

(b) The disputing health care professional or inpatient hospital must provide the agency with the following information:

(i) The health care professional or inpatient hospital's assessment of the PPC; and

(ii) A complete copy of the client's medical record and all associated billing records, to include itemized statement or explanation of charges.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-550-1650 Adverse events, hospital-acquired conditions, and present on admission indicators. ((~~(1) The rules in this section apply to:~~

~~(a) Inpatient hospital claims with dates of admission on and after January 1, 2010;~~

~~(b) Payment or denial of payment for any inpatient hospital claims identified in (a) of this subsection, including medicaid supplemental or enhanced payments and medicaid disproportionate share hospital (DSH) payments or denial of payment;~~

~~(c) Adverse events, hospital-acquired conditions (HACs), and present on admission (POA) indicators (defined in subsection (2) of this section);~~

~~(d) Hospital requirements to report adverse events and HACs to the department (see subsection (4)(a) of this section);~~

~~(e) Hospital requests for retrospective utilization reviews and the related requirements to provide root cause analysis of events to the department (see subsection (4)(d) through (f) of this section); and~~

~~(f) Hospital requirements to use POA indicator codes on claims (see subsection (5)(a) of this section).~~

~~(2) The following definitions apply to this section:~~

~~(a) "**Adverse events**" (also known as "adverse health events" or "never events") are the events that must be reported to the department of health (DOH) under WAC 246-320-146. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the health care organization.~~

~~(b) "**Hospital-acquired condition (HAC)**" is a condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission. For medicaid payment purposes, the department considers a HAC to be a condition that:~~

~~(i) Is high cost or high volume, or both;~~

~~(ii) Results in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis;~~

~~(iii) Could reasonably have been prevented through the application of evidence-based guidelines; and~~

~~(iv) Does not conflict with medicare's hospital-acquired conditions policy (http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage).~~

~~(c) "**Serious disability**" means a physical or mental impairment~~

~~that substantially limits the major life activities of a patient.~~

~~(d) **"Present on admission (POA) indicator"** is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)~~

~~(e) **"Root cause analysis"** is a class of problem-solving methods aimed at identifying the root causes of events instead of addressing the immediate, obvious symptoms.~~

~~(3) **Medicare crossover inpatient hospital claims.** The department applies the following rules for these claims:~~

~~(a) If medicare denies payment for a claim at a higher rate for the increased costs of care under its HAC and/or POA indicator policies:~~

~~(i) The department limits payment to the maximum allowed by medicare;~~

~~(ii) The department does not pay for care considered nonallowable by medicare; and~~

~~(iii) The client cannot be held liable for payment.~~

~~(b) If medicare denies payment for a claim under its National Coverage Determination authority from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:~~

~~(i) The department does not pay the claim, any medicare deductible, and/or any co-insurance related to the inpatient hospital services; and~~

~~(ii) The client cannot be held liable for payment.~~

~~(4) **Inpatient hospital claims related to adverse events (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section).** The department applies the following rules for these claims:~~

~~(a) When the department requests information from a hospital regarding adverse events identified by DOH, the hospital must provide the information requested for any affected medical assistance client (this includes both fee-for-service clients and clients enrolled in a managed care organization (MCO) contracted with the department). If no medical assistance client was affected by an adverse event, the hospital must provide a written response to the department with an assurance that no medical assistance clients were affected.~~

~~(b) The department does not pay for adverse events identified by DOH and/or identified through the department's retrospective utilization review process. Some HACs can become an adverse event if the:~~

~~(i) Patient dies or is seriously disabled; or~~

~~(ii) Level of severity is great, such as the patient develops level three or level four pressure ulcers.~~

~~(c) The client cannot be held liable for payment.~~

~~(d) A hospital may request a retrospective utilization review by the department, as described in WAC 388-550-1700 (6)(a) and~~

~~(b)(iii), from the department or its designee to determine if the hospital is eligible for a partial payment for the adverse event.~~

~~(e) A hospital that requests a department retrospective utilization review of an adverse event must provide the department with the hospital's root cause analysis, as described in WAC 246-320-146 (3) and (4), of the adverse event claim.~~

~~(f) The health care information that is part of the retrospective utilization review, including the root cause analysis of the adverse event claim, is exempt from public disclosure under RCW 42.56.360 (1)(c).~~

~~(5) Inpatient hospital claims related to hospital-acquired conditions that do not qualify as an adverse event (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section). The department applies the following rules for these claims:~~

~~(a) The department reviews POA indicator codes on inpatient hospital claims in order to determine if a condition was present or incubating at the time the order for inpatient admission occurred, if a condition occurred during, or as a result of, hospital care, or if a condition developed during an outpatient encounter.~~

~~(i) All hospitals that have signed a core provider agreement with the department must provide information to the department by using POA indicator codes on each claim (refer to the table in this subsection).~~

~~(ii) These POA indicator codes must designate which procedures or complications were present on admission, and which occurred during, or as a result of, hospital care.~~

~~(iii) POA indicator codes are to be assigned to principal and secondary diagnosis (as defined in Section II of the Official Guidelines for Coding and Reporting), and the external cause of injury codes.~~

~~POA Indicator Codes~~	
~~Code~~	~~Reason for Code~~
~~Y~~	~~Diagnosis was present at time of inpatient admission.~~
~~N~~	~~Diagnosis was not present at time of inpatient admission.~~
~~U~~	~~Documentation insufficient to determine if condition was present at the time of inpatient admission.~~
~~W~~	~~Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission.~~

~~(b) The department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U." Specifically, for hospitals paid under the:~~

~~(i) Diagnostic related group (DRG) payment method, the department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).~~

~~(ii) Per diem payment method, the department does not pay for days beyond the average length-of-stay (LOS) (defined in WAC 388-550-1050).~~

~~(iii) Departmental weighted costs-to-charges (DWCC) payment method, the department does not pay for services attributable to the HAC.~~

~~(iv) DRG and per diem outlier payment methods, the department does not pay for services attributable to the HAC.~~

~~(v) Ratio of costs-to-charges (RCC) payment method, the department does not pay for services attributable to the HAC.~~

~~(vi) Per case payment method, the department does not pay for services attributable to the HAC.~~

~~(6) The department denies payment for any HAC that results in death or serious disability.~~

~~(7) A hospital that disagrees with a department decision to deny payment or partial payment of an adverse event or hospital-acquired condition may follow the administrative appeal process in WAC 388-502-0220.~~)) Refer to WAC 182-502-0022 for the payment policy for provider preventable conditions.