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 (PPC).

(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 published by the National Quality Forum at: http://www.qualityforum.org/News_And_Resources/Press_Releases/2011/NQF_Releases_Updated_Serious_Reportable_Events.aspx.

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

(e) **Provider preventable condition (PPC)** – An umbrella term for hospital and non-hospital 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 (OPPC).

(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; or

(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 (DVT)/pulmonary embolism (PE) following certain orthopedic precedures:

(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 indicated will prompt review of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines.

(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 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 current National Quality Forum list of serious reportable events in health care effective on the date the incident occurred. The National Quality Forum list of serious reportable events, 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 health care professionals and inpatient hospitals with a signed core provider agreement to report PPCs 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 intent to bill the agency.

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

(i) A condition was present or incubating 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 a PPC associated with a Medicaid client in accordance with chapter 70.56 RCW within thirty calendar days of filing the PPC with the Department of Health. Notification must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, client identifier, attending provider, the POA indicator if applicable, and the claim number if the facility submits a claim to the agency. Hospitals 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/. *(Form not available at this link yet.)*

(e) Health care professionals responsible for, or involved with, a PPC associated with a Medicaid client in accordance with chapter 70.56 must notify the agency within thirty calendar days of the PPC. 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/. *(Form not available at this link yet.)*

(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 WAC chapter 182-502A); and
(v) A provider or client complaint.

(8) Payment adjustment for PPCs

(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 co-morbid 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) The agency makes no payment, facility or professional, and denies payment for any PPC claim that is directly attributable to death or serious disability.

(e) 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 USC 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 that 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.

AMENDED SECTION
WAC 182-550-1650 Adverse events, hospital-acquired conditions, and present on admission indicators.

Refer to WAC 182-502-0022 for the payment policy for provider preventable conditions.

(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 healthcare 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 healthcare 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.

EXTERNAL REVIEW COMMENTS
Provider Preventable Conditions (PPCs)
WAC 182-502-0022 & 182-550-1650

SUMMARY OF COMMENTS RECEIVED	THE DEPARTMENT CONSIDERED ALL THE COMMENTS. THE ACTIONS TAKEN IN RESPONSE TO THE COMMENTS, OR THE REASONS NO ACTIONS WERE TAKEN, FOLLOW.
WAC 182-502-0022 (4) Health Care Acquired Condition (HCAC) - The agency will deny or recover payment to healthcare 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 The definition of trauma should also include mental health trauma. This should not just be a consideration for this subsection, but throughout this section.	**NO CHANGE WAS MADE AS A RESULT OF THIS COMMENTS** Thank you for your comments. This definition mirrors the federal definition found in 42 CFR §447.26(3)(b). The Agency is not expanding on the definition at this time.
	SOME CHANGES WERE MADE AS A RESULT OF THESE COMMENTS
WAC 182-502-0022(3)(a) Define Agency as HCA	Agency is defined in WAC 182-500-0010. The Agency will add a cross reference to the definition.
WAC 182-502-0022(3)(b) HCAC link from CMS – to maintain an accurate list of HCACs • NCD – CMS needs to be added	The Agency added a link to Medicare's list of Hospital Acquired Conditions (HCAC).
WAC 182-502-0022(4): Add: *"HCAC, when they overlap with NQF adverse events"*	The Agency disagrees.
WAC 182-502-0022(4)(a) Remove. Should be captured in the CMS link above in 3(b)	The Agency wishes to keep the list spelled out in (4)(a).
WAC 182-502-0022(5)(e)(ii-vii): Remove in its entirety	The Agency wishes to keep the list spelled out in (5)(e)(ii-vii).

SUMMARY OF COMMENTS RECEIVED	THE DEPARTMENT CONSIDERED ALL THE COMMENTS. THE ACTIONS TAKEN IN RESPONSE TO THE COMMENTS, OR THE REASONS NO ACTIONS WERE TAKEN, FOLLOW.
WAC 182-502-0022(6)(b): Delete	The Agency cannot delete this. This is a direct requirement of 42 CFR §447.26(d) Reporting. Under the final Medicaid regulation, States must require that providers participating in Medicaid identify PPCs associated with Medicaid patients even if the provider does not intend to bill Medicaid. See also CMS' Frequently Asked Questions page, Q6/A6 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/PPCFAQ-41012.pdf
WAC 182-502-0022(6)(d) Remove: " "Notification"..	The Agency disagrees with deleting. However, the Agency did reword the following two subsections. (d) Hospitals must notify the agency of a PPC associated with a Medicaid client in accordance with chapter 70.56 RCW in writing within thirty calendar days of filing the PPC with the Department of Health. Notification must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, client identifier, attending provider, the POA indicator if applicable, and the claim number if the facility submits a claim to the agency. Hospitals 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/. *(The form will be available before final publishing of rule.)* (e) Health care professionals responsible for, or involved with, a PPC associated with a Medicaid client in accordance with chapter 70.56 must notify the agency within thirty calendar days of the PPC. 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/. *(The form will be available before final publishing of rule.)*
WAC 182-502-0022(8)(d) Delete – Duplicate of 8(e)	The Agency agrees and will strike (8)(d).

SUMMARY OF COMMENTS RECEIVED	THE DEPARTMENT CONSIDERED ALL THE COMMENTS. THE ACTIONS TAKEN IN RESPONSE TO THE COMMENTS, OR THE REASONS NO ACTIONS WERE TAKEN, FOLLOW.
REPORTING REQUIREMENTS: **WAC 182-502-0022(6)(a) and (6)(b) Core provider agreements.** This section requires healthcare professionals and inpatient hospitals "with a signed core provider agreement" to report PPCs. We find the simple requirement to report under 42 C.F.R. § 447.26(d) sufficient. Further, the requirement for a physician to have a 'signed core provider agreement' could have the detrimental effect of causing some providers to drop their core provider agreement in order to avoid the potentially onerous reporting requirements.	SOME CHANGES WERE MADE AS A RESULT OF THESE COMMENTS All health care professionals, health care entities, suppliers, or contractors of service who conduct business with the Agency must have an approved Core Provider Agreement (CPA) with the agency or be a performing provider on an approved CPA with the Agency in order to be paid. The Agency will remove the words, "with a signed Core Provider Agreement" as that requirement is already found under WAC 182-502-0005. 42 CFR § 447.26(d) directs the Agency to require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.
WAC 182-502-0022(6)(e) – Defining terms for reporting requirements. The language in section (6)(e) notes that a "failure to *properly* report,..." could result in a loss or denial of payments, and even worse, sanctions including termination of the core provider agreement and exclusion from the Medicaid program. The word "properly" is not defined and should be stricken, or if not, it should be broadly defined. Because the penalties for not reporting are steep (i.e., loss of payment and/or termination from Medicaid), at the very least the word "properly" should be explicitly defined such that a physician knows exactly what they are expected to do in their reporting of conditions.	*(Now (6)(f))* - The Agency agrees and will remove the word "properly."
WAC 182-502-0022(8)(e) – "Formats used for patient record" This section references the "patient record." These terms are vague and undefined. There are many different patient records and those records may exist in many different forms, versions, and locations. We seek clarity on what is meant by documenting in the "patient record."	A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS The Agency will revise the proposed language to clarify it is the "client's clinical record..."
WAC 182-502-0022(6)(e) – Penalty for failure to report – exclusion from Medicaid. An exclusion from Medicaid exceeds the scope of 42 C.F.R. § 447.26 and should be removed. The penalty of exclusion from participation in Medicaid is far too steep of a penalty and should be softened. As we mentioned above, the Medicaid system in under great stain already and that strain will be compounded in 2014. Sanctions of this magnitude for failing to "properly report" provider preventable conditions may jeopardize access to care for Medicaid clients.	*(Now (6)(f))* - The Agency struck the following text from the proposed rules: (6)(e) Failure to properly report, code, bill or claim PPCs will result in loss or denial of payments ~~and/or potential sanctions, including but not limited to termination of the core provider agreement and exclusion from participation in Medicaid~~.

SUMMARY OF COMMENTS RECEIVED	THE DEPARTMENT CONSIDERED ALL THE COMMENTS. THE ACTIONS TAKEN IN RESPONSE TO THE COMMENTS, OR THE REASONS NO ACTIONS WERE TAKEN, FOLLOW.
WAC 182-502-0022(6)(e) – Penalty for failure to report – other sanctions. Other sanctions are mentioned under (6)(e) but are not defined. For the reasons stated in the comments above, the sanctions should be softened and should not result in a disincentive to participate in the Medicaid system. *(See comment below on reducing access to care).*	The Agency struck language in question.
WAC 182-502-0022(6)(a) – Reporting requirements – present on admission conditions. These requirements of reporting would place a burden on physicians participating in an already compromised system. The proposed rule requires healthcare professionals *and* in-patient hospitals to report present on admission (POA) conditions. This is a significant burden and places a high degree of pressure on the physicians to report in order to get reimbursed and avoid sanctions. We recognize the need to report, but the reporting burden is too much on the physician.	This is a federal requirement under 42 CFR § 447.26(d) which directs the Agency to require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. During the course of a history and physical, conditions present on admission should be clearly documented on the clinical record. As such, this should not be an additional burden for providers. It is an expectation that medical conditions are identified and documented on the clinical record.
WAC 182-502-0022(6)(a) – Reporting requirements. HCPCS modifiers and POA codes are not defined or referenced anywhere in the proposed rule. In order to make reporting simpler, reduce the administrative burden on health care providers, and encourage more consistent reporting, physicians need to understand the requirements to which they need to adhere. For example, HCPCS modifiers and POA codes need to be easily accessible and easily reportable. **REPORTING COMPLICATIONS:** **WAC 182-502-0022(8)(a) – conditions that existed prior to initiation of treatment.** The proposed rules do not take into account pre-morbid conditions and habits of patients prior to hospital admission. The presence and severity of conditions occurring before a hospital admission (co-morbidities) will vary greatly among patients, as will pre-existing factors beyond the control of the physician or hospital (such as smoking, patient noncompliance, obesity). These factors, and the fact that each patient might receive care from multiple physicians, make the identification and determining the causation of a PPC or Health Care Acquired Condition (HCAC) nearly impossible. <u>We recommend that the agency create risk-adjustment mechanisms to allow a provider to compensate for patients with above and below-average risks.</u>	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** Modifiers and POA codes do not belong in rule as they do tend to change and/or are updated by CMS. The HCPCS modifiers are easily accessed in the HCPCS books and billing software. The POA indicators are listed in the Agency's Inpatient Hospital Medicaid Provider Guide, page G.7 and G.8, located online at: http://maa.dshs.wa.gov/download/Billing_Instructions_Webpages/Hospital_Inpatient.html The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (a) The agency does not reduce, <u>recoup, or deny</u> 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 <u>(ii) Is directly attributable to a co-morbid condition(s).</u>

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<u>DECREASES IN ACCESS TO CARE</u>: **42 CFR § 447.26(c)(5) requires that the implementation of this rule cannot result in a decrease in access to care**. It is unclear from the proposed rule how a decrease in access to care will be measured if the rule is not adhered to. The Agency must ensure that any non-payment rules put into effect do not result in a loss of access to care[1] or services for Medicaid patients. Because the reporting requirements detailed in the proposed rule are onerous, and the potential sanctions severe, implementation of the rule could result in providers declining to sign or terminating the core provider agreement thus decreasing access to care. We urge the Agency to actively monitor and study the impact of extending the Washington specific policy and to conduct a detailed cost/benefit analysis.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS The Federal rule mandates states to implement this PPC rule. Washington State worked with CMS and decided to limit implementation to the inpatient setting. The scope of the federal rules allowed the states at its discretion to expand these rules to all providers regardless of setting. However, the Agency is only implementing the minimum requirement at this time.
WAC 182-502-0022 Provider Preventable Conditions (PPCs) – Payment Policy I am a mental health professional working with Medicaid and Medicare recipients in nursing homes (short- and long term). I also worked in the legal filed, both with insurance defense and plaintiff sides. As a non-profit health care provider, I am very serious about my fiduciary responsibility of Medicaid monies as I am a tax payer who funds Medicaid and Medicare, and sees some recipients who cause increased costs because of poor choices that result in preventable and exacerbate medical conditions.	NO CHANGES WERE MADE AS A RESULT OF THESE COMMENTS The Agency thanks the commenter for submitting these comments. The Agency stresses to providers the importance of thorough documentation in the clinical record will provide a level of protection for providers.

[1] HHS Office of Inspector General (OIC) produced a report addressing key issues in implementing the HAC policy (Adverse Events in Hospitals: Overview of Key Issues (OEI-06-07-00470)). In this report, the OIG found that HAC nonpayment policies are increasingly popular among payers and that these policies have drawbacks and may "limit access to care, increase hospital costs, and reduce hospital revenues."

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I applaud this needed attempt to hold the appropriate parties fiscally responsible for preventable conditions from medical negligence. However, based on my professional familiarity with the reality of co-occurring medical and mental illness, I have some concerns and respectfully submit and share some realities. **POA Indicator** • I have seen hospitals/ER admission records that reflect only the immediate presenting problem and brief history and past medical conditions. This is often understandable given the inherent nature of an ER admission; focus immediate problem to keep the patient alive; patient unconscious; patient and/or loved ones giving incomplete hx under the panic circumstances or intentional (shame, substance abuse). • A condition may not have been previously diagnosed, and discovered only through additional testing that are done based on symptoms that show up after the initial admission (e.g., diabetes, hypertension, hypothyroidism, kidney or liver disease, heart disease, unknown allergies, dementia, asymptomatic UTI, etc.) • Some post-admission conditions are the unfortunate side effects of medications or treatments for the initial reason for admission (e.g., medication created diabetes, hypertension, atrial fibrillation, allergic reaction to medications or combination of medications). The choice often is death or life with the new conditions. One part of a comprehensive solution to this would be the universal access to electronic health records. Unfortunately, this is a very difficult and "big brother" method.	NO CHANGES WERE MADE AS A RESULT OF THESE COMMENTS The Agency thanks the commenter for submitting these comments.

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WAC 182-502-0022(4) HCAC Conditions • MRSA/Staph infections should added as they should be preventable, albeit difficult, and area significant problem because of increasingly drug-resistance.	NO CHANGES WERE MADE AS A RESULT OF THESE COMMENTS Thank you for your comments. These conditions mirror the federal list found in: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.
• These are not always the result of medical negligence. Sometimes these are the result of: ✓ Patient non-compliance by choice or ignorance or by influence of unknown or uncontrolled mental illness (delirium, dementia, psychosis, mood disorder, anxiety, etc.) ✓ Patient's physical condition (e.g., morbid obesity, unconscious so cannot aid in proper care or tell about symptoms). ✓ Loved one's interfere, whether from misguided love for or intimidation by patient (food, trying to assist with ambulation, going against medical advice). • Patients have the right to leave or do things against medical advice. Medical providers (and the world) are not responsible for a patient's poor fully informed decisions. • Patients can hide signs of suicidal thoughts or feelings, even with standard screening. Mandatory suicide screening when not indicated could be malpractice, not to mention cause a patient and loved ones additional anxiety or discomfort to an already difficult situation. Suicidal thoughts and feelings still have a very bad stigma attached.	The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (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 co-morbid condition(s).

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• To avoid negative financial consequences, i.e., to ensure these do not occur would require forcing certain patients to do something they don't choose to (even it is for their own good) or forcing them with restraints – physical or chemical. Or a significant increase in the (penny wise/pound foolish) practice of discharging a patient as soon as possible to a lesser level of care when the patient is medically barely stable enough to recover and prevent complications outside of a hospital level of care, which then results in subsequent ER readmission (and more costs as the patient will be weaker and with more problems).	Thank you for your comment.
Unintended but Predictable Consequences While the non-payment for medical negligence is appropriate and justified, • Medical providers will incur more costs which they **will** pass on to the consumer via higher fees. The medical provider increased costs will be for: o More legal/fiscally driven preventative diagnostic tests and documentation as healthcare focus will be on documentation for prevention of lost money or lawsuits rather than patient care – which counters part of the intent of this proposal. o The administrative appeals, and o Increased number of lawsuits by patients (a reasonable expectation)	Thank you for your comment.

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• This, in turn, will result in higher medical insurance rates. How? No legislation exists that addresses passing on costs to consumer in order to maintain a healthy profit margin and executive salaries. • Medicaid patients already have a difficult time finding medical providers because many have limited their Medicaid caseload due to the insufficient reimbursement and paperwork. This proposal may further reduce the number of medical providers servicing Medicaid patients. Unfortunately, given the complexity of the healthcare system, I have no easy suggestions. I assume various medical review boards were involved in the drafting of this proposal, and suggest that Chief Medical Officers and Quality Assurance committees of hospitals, and small and big health care providers participate in any review or revision. They are the ones who could contribute to a whole/bigger picture of the realities of providing care, and can assist with finding ways that address preventable medical events effectively and meaningfully, i.e., reasonably based on reality and medical standards, and can be implemented and enforced.	This policy is already in effect for hospitals; this rule simply expands the policy to include the professional payments as required by the Affordable Care Act.

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WAC 182-502-0022 Provider Preventable Conditions (PPCs) While some changes may be appropriate, we have significant concerns about the external review draft. We ask rulemaking be delayed until we have had a chance to discuss its intent and the proposed changes in process. We are interested in exploring alternative approaches that can be used to achieve the Authority's goals. We feel strongly the state should not add to the complexity of current quality reporting requirements on hospitals nor breach important legal protections built into the quality review process. In addition, we are concerned about denying total payment for extremely expensive patients who received mostly appropriate care. Our general concerns are addressed below. Specific concerns are outline in the enclosed document.	**CHANGES WERE MADE AS A RESULT OF THESE COMMENTS** The federal rules were effective July 1, 2011, with a delay of implementation and enforcement until July 1, 2012. The Agency cannot delay these rules.
Reporting requirements As drafted, the rule appears to require hospitals report to the Authority for hospital-acquired conditions, even when these conditions are not serious reportable conditions. This would impose an extensive new reporting requirement on hospitals. The Authority currently is informed about hospital-acquired conditions through the billing process. When a condition appears on the claim and the condition has not been identified as existing prior to admission through the use of a Present on Admission indicator, the Authority assumes this condition was hospital acquired. We believe this process should be sufficient for the Authority; no additional reporting should be required for conditions which are not serious reportable events. This is the process currently used for Medicare claims.	This is a federal requirement under 42 CFR § 447.26(d) which directs the Agency to require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. The Agency has revised the proposed language.

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If the intent is to keep the current process in place, we ask the Authority to clarify the wording. For examples, in Section (6)(b), the proposed rules state "providers must report conditions identified for nonpayment when they occur regardless of whether or not the provider intends to bill the Authority? Is the Authority proposing a new reporting requirement beyond those presently provided to the Authority for billing purposes? If the intent of the rule is to simply gather additional information about adverse events reported currently to the WA State Department of Health, we believe again that additional clarity is needed. WSHA is concerned with the differences in how the Authority and the Department define adverse events. In Chapter 70.56 RCW, the Department defines adverse events in reference to "the list of serious reportable events adopted by the *national quality forum…*" This existing definition does not include CMS' hospital-acquired conditions which is included in the Authority's definition.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** This is a federal requirement under 42 CFR § 447.26(d) which directs the Agency to require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. The Health Care Authority is updating its rules to match the federal requirements which expands the conditions and adds licensed health care professionals. These rules are separate from the Department of Health and directly mirror the Affordable Care Act. The Agency has revised the proposed text for clarification.
Maintenance of Quality Review Protections The external review draft proposes hospitals report to the Authority when an adverse event has been reported to the Department of Health. Hospitals are being asked to report the event, date of service, client identifier, all the involved providers, and the Present on Admission indicator, if applicable. We are concerned such broad reporting will jeopardize hospital quality assurance protections. We are also concerned hospitals are asked to notify the Authority about providers simply on staff at the hospital but not hospital employees. If additional reporting is required to the Authority, we ask the items be limited to event, date of event, claim number, attending physician, and Present on Admission indicator, if applicable. In addition, some items such as claim number may not be available until the patient is discharged. Requiring notification within 10 days of reporting to the Department may not be practical.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency has revised the proposed rule for clarification and changed the 10 business day reporting requirement to 30 calendar days.

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Denial of Payment The external draft proposed to deny payment for all serious reportable events and health care-acquired conditions which result in death or serious disability, with serious disability defined as loss of bodily function at discharge or for outpatients lasting seven days. A hospital may provide care for months to a medically complex patient who ultimately expires or has a serious condition. It may be clinically impossible to assess what degree the event contributed to the death or serious condition. It does not seem appropriate to deny payment for the entire admission. The proposal broadens the current policy by changing the definition of serious condition to make it a loss of bodily function for seven days or at time of discharge. It also broadens the application to hospital-acquired conditions. We believe these changes can inappropriately penalize hospitals and providers giving appropriate care.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (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 co-morbid condition(s).
WAC 182-502-0022(3)(a) Definitions **Adverse event** - A discrete, auditable, and clearly defined occurrence as identified by the National Quality Forum in its list of serious adverse events in health care, see subsection (5) or an event identified by the Centers for Medicare and Medicaid Services that leads to a negative consequence of care resulting in unintended injury or illness that was preventable. The National Quality Forum's List of Serious Adverse Events is also available at: http://www.qualityforum.org/News_And_Resources/Press_Releases/2011/NQF_Releases_Updated_Serious_Reportable_Events.aspx [We] are concerned with the differences in how the Health Care Authority and the WA State Department of Health define adverse events. The WA State Department of Health defines adverse events using the National Quality Forum's list only. Since there are overlaps between CMS hospital-acquired conditions and the National Quality Forum, WSHA recommends using the WA State Department of Health's definition in Chapter 70.56 RCW and Chapter 246-302-010 WAC. One additional technical change to include: CMS hospital-acquired conditions is listed in subsection (4) of the proposed rules.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency deleted the definition for Adverse Events. In this rule, Other Provider Preventable Conditions has replaced Adverse Events (and is defined to mean the National Quality Forum's list only).

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WAC 182-502-0022(3)(b) Definitions **Health care-acquired conditions (HCAC)** – Technical change: CMS hospital-acquired conditions is listed in subsection (4) of the proposed rules.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** Fixed
WAC 182-502-0022(3)(g) Definitions **Serious** – [We] question how was this definition was determined. A loss of bodily function can be present at discharge or last for more than seven days, but not expected to be permanent.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency has deleted this definition.
WAC 182-502-0022(6)(a) & (b) Reporting PPCs [We] are concerned that the Authority is requiring hospitals to report hospital-acquired conditions, even when these conditions are not serious reportable conditions. This would impose an extensive new reporting requirement on hospitals. [We] believe that any additional reporting should be limited to serious reportable events. Please clarify why this information is needed when hospitals are not billing the Authority? Is the Authority proposing a new reporting requirement beyond those presently provided to the Authority for billing purposes?	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** This is a direct requirement of 42 CFR §447.26(d) Reporting. Under the final Medicaid regulation, States must require that providers participating in Medicaid identify PPCs associated with Medicaid patients even if the provider does not intend to bill Medicaid. See also CMS' Frequently Asked Questions page, Q6/A6 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/PPCFAQ-41012.pdf
WAC 182-502-0022(6)(d) Reporting PPCs [We] are concerned that broad reporting will jeopardize hospital quality assurance protections. [We] also are concerned hospitals are asked to notify the Authority about providers simply on staff at the hospital but not hospital employees. If additional reporting is required to the Authority, we ask the items be limited to event, date of event, claim number, attending physician, and Present on Admission indicator, if applicable. [We] are also concerned about the 10 business-day notification requirement. Some information such as claim number may not be available until the patient is discharged. Requiring notification within ten days of reporting to the Authority may not be practical.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** *Now subsection (6)(e)* - The Agency has revised the proposed rule for clarification and changed the 10 business day reporting requirement to 30 calendar days.

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WAC 182-502-0022(8)(d) & (e) Payment adjustment for PPCs It does not seem appropriate to deny payment for the entire admission. A hospital may provide care for months to a medically complex patient who ultimately expires or has a serious condition. The proposal broadens the current policy by changing the definition of serious condition to make it a loss of bodily function for seven days or at time of discharge. It also broadens the application to hospital-acquired conditions. [We] believe these changes can inappropriately penalize hospitals and providers giving appropriate care.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (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 co-morbid condition(s).
WAC 182-502-0022(3)(f) Provider preventable condition (PPC) – Definition This definition presumes every situation which is included in the Health Care Acquired Conditioned (HCAC) list below is preventable. Some of the conditions listed as HCACs are not preventable in every patient situation. We would be happy to provide examples upon request.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (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 co-morbid condition(s).

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WAC 182-502-0022(6) Reporting PPCs This section as a whole is not as clear as it could be. (6)(b) How providers are to report conditions when the provider does not plan to generate a claim based on its own internal policies is unclear under the draft rule (6)(d) The regulation needs to provide a definition of the term "involved provider." Additionally, the notification date should be changed to be the later of ten business days from filing the adverse event report with DOH or ten business days from patient discharge. Hospitals will not have all of the information requested by the agency until the admission is complete and coded, which may be long after the adverse event and filing of any required DOH report on it.	**A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency added a new subsection (6)(f) to explain how health care professionals are to report PPCs. Notification must be in writing and be addressed to the agency's Chief Medical Officer. In the revised language 182-502-0022(6)(d), the Agency struck the language regarding "all involved providers" and changed it to "attending provider." Also, the Agency changed the ten business days to thirty calendar days.
WAC 182-502-0022(8)(d) Payment adjust for PPCs See comment above in section (3)(f). A hospital may provide care for months to a medically complex patient who ultimately expires. If at some point during that patient's admission the patient had an HCAC such as a catheter-associated infection it may be clinically impossible to assess to what degree that infection did or did not contribute to the expiration. It does not seem appropriate to categorically deny payment for the entire admission which included months of suitable and appropriate care prior to expiration.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** The Agency conducts comprehensive chart reviews and has added the following to the proposed rules: (8) Payment adjustment for PPCs (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 co-morbid condition(s).

cc: HCA Rules Coordinator