District of Columbia

Department of Health Care Finance

Payment Adjustment for Provider-Preventable Conditions

Frequently Asked Questions

The District of Columbia Department of Health Care Finance (DHCF) is implementing a new policy required by federal law that prohibits Medicaid payment for services related to provider-preventable conditions (PPCs).

This document provides questions and answers about the new payment policy. ***Please note that changes, while unlikely, remain possible before the implementation date.***

DHCF is scheduling training sessions for interested providers; please see page 7 for additional information.

OVERVIEW

1. What are the federal requirements for provider-preventable conditions?

The federal requirements are part of the Patient Protection and Affordable Care Act (PPACA or the Affordable Care Act) which prohibits federal payments to states for Medicaid services related to health care-acquired conditions effective July 1, 2011, and requires CMS to issue regulations.

On June 1, 2011, CMS published final regulations for Medicaid programs nationwide. CMS titled these provisions "Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions." Provider-preventable conditions (PPCs) include at a minimum: "health care-acquired conditions" (HCACs) and "other provider-preventable conditions" or OPPCs. OPPCs are sometimes referred to as erroneous surgical or other invasive procedures. The CMS rule was effective July 1, 2011; however, CMS delayed compliance enforcement until July 1, 2012, to allow Medicaid programs time to develop and complete implementation of PPC policies.

2. What is the DHCF Provider-Preventable Conditions Payment Adjustment policy?

DHCF's payment adjustment policy for provider-preventable conditions implements the federal requirements that prohibit Medicaid payment for certain health care-acquired conditions and other provider-preventable conditions (erroneous surgical or other invasive procedures). These conditions are collectively known as provider-preventable conditions (PPCs).

3. What change is being made?

Medicaid providers will no longer be reimbursed for services relating to a specified list of health care-acquired conditions or HCACs when the condition is acquired during the hospital stay; that is, when the patient did not have the condition when admitted to the hospital. In addition, no payment will be made for OPPCs (erroneous surgical or other invasive procedures) and services directly related to the wrong surgery, when the practitioner erroneously performs a procedure.

4. When is this payment policy effective?

July 1, 2012.

5. What providers will be affected?

The provider-preventable conditions payment adjustment provision applies to all providers participating in the District of Columbia Medicaid program. Generally, this includes the following providers:

- *For health care-acquired conditions.* All inpatient hospitals participating in the D.C. Medicaid program, including in-District and out-of-District hospitals including District owned hospitals, psychiatric hospitals, rehabilitative hospitals, and long term acute care hospitals.

  The HCAC payment adjustment policy does not apply to physicians who treat Medicaid beneficiaries for HCACs but bill separately for these services.

- *For erroneous surgical or other invasive procedures or (OPPCs).* Any provider participating in the D. C. Medicaid program, including inpatient and outpatient hospitals, ambulatory surgical centers, and any practitioner who may do surgeries in hospitals or other health care settings.

6. How are Medicaid PPCs different from Medicare hospital-acquired conditions and the three national coverage determinations (NCDs) for wrong procedures?

The minimum requirements for Medicaid PPCs are virtually identical to Medicare's "Hospital-Acquired Conditions and Present on Admission Indicator Reporting (HACs & POA)" and for NCDs for wrong procedures. Generally, the major differences include:

- Health care-acquired condition requirements apply to all inpatient hospitals under Medicaid, regardless of how the hospital is paid. Medicare, however, exempts certain hospitals such as children's hospitals, psychiatric hospitals, long term care, rehabilitation hospitals, Maryland hospitals and other hospitals that are not paid by DRGs.

- The list of Medicaid HCAC conditions is the same as for Medicare, with one exception: deep vein thrombosis/pulmonary embolism following total knee/hip replacement is not considered a HCAC for Medicaid pediatric (individuals under 21) and obstetric patients.

7. What services will be affected?

- *For health care-acquired conditions*. All inpatient hospital services provided to D. C. Medicaid beneficiaries when any of the specified HCACs are present as a secondary diagnosis and acquired during the stay.

- *For erroneous surgical or other invasive procedures (OPPCs).* Surgical or other invasive procedures to treat a particular medical condition when the practitioner erroneously performs the procedure (wrong procedure, wrong body part, or wrong patient). Hospitalizations and other services related to the erroneous procedure will also be affected.

8. Will the change affect payments by managed care plans?

Yes, managed care plans are also required to limit payment of Medicaid claims for HCACs and OPPCs.

9. Will the change affect payments of Medicare crossover claims?

Yes, DHCF will limit payment of Medicare crossover claims when a Medicare Hospital Acquired Condition (HAC) or an erroneous surgery or procedure is submitted on the claim. If Medicare reduces payment due to a HAC or denies a claim due to an erroneous surgery, D.C. Medicaid may also reduce or deny payment. In addition, Medicaid payment of crossover claims may be reduced due to a health-care acquired condition for inpatient hospitals exempt from Medicare HACs.

10. For claims paid by DRG, how will payment be adjusted when a specific health care-acquired condition is present on the claim?

Claims paid by DRG will be adjusted using specific HCACs logic supplied with the 3M™ AP-DRG grouper software. This process functions in a similar way as the Medicare DRG grouper logic does for the Medicare HACs.

The DHCF claims processing system will identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the AP-DRG. Payment for the stay would therefore only be affected if the presence of the HCAC would otherwise have pushed the stay into a higher-paying AP-DRG. DRG claims will continue to be priced by DRG with payment reduced if removing the HCACs results in a DRG with a lower relative weight.

11. For hospitals paid by other payment methods, how will payment be adjusted when a specific health care-acquired condition is present on the claim?

Non-DRG claims will price according to existing payment methodologies for the provider (e.g., per diem). However, these claims will go through the HAC logic of the AP-DRG grouper software in order to determine whether the HCAC affects payment and to calculate the proper payment adjustment, if applicable. DRG assignment will be used for the purpose of identifying the effect of a HCAC on the resources needed to care for a patient.

This process will function in the same manner as for DRG claims (see question 18). If removing the HCAC results in a DRG with a lower relative weight, then payment will be affected. Payment would be adjusted by a percentage based on the difference in the DRG weights. For example:

DRG weight before removing the HCAC:	1.50
DRG weight after removing the HCAC:	1.20
Post-HCAC DRG weight as a percentage:	80%
Facility per diem rate:	$500.00
Length of stay (LOS):	4 days
Claim price before removing the HCAC:	$500 X 4 = $2,000
Claim price after removing the HCAC:	($500 X 4) X (1.20 /1.50) = ($2,000 X .80) = $1,600

12. Will providers know if the claim payment was reduced due to a HCAC?

Yes. The provider's remittance advice will have an explanation of benefits (EOB) to let providers know when payment was reduced due to a HCAC.

13. For hospitals paid by Non-DRG, will the payment adjustment policy affect the cost report process?

Yes. Adjustments will also be made during the cost settlement process so that hospital costs associated with health care-acquired conditions are not reimbursed by the Department.

PRESENT-ON-ADMISSION (POA) INDICATOR

14. What is the present-on-admission (POA) indicator?

The present-on-admission indicator (POA) is the method that a hospital uses to identify which patient conditions were present on admission and which conditions developed while hospitalized. The POA indicator is assigned to each reported diagnosis code, for principal and secondary diagnoses. The POA must be reported for external cause of injury codes (E-codes) when the E-code is included in a secondary diagnosis code field locator (FL 67 A-Q).

For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, please visit http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf to see the *ICD-9-CM Official Guidelines for Coding and Reporting*. (See question 29 for other sources of information.)

15. Is the POA indicator required on Medicaid claims?

Yes. The POA will be required on all claims involving inpatient admissions to all hospitals that are subject to the DHCF PPC payment policy. This requirement applies to claims submitted on paper (UB-04) and electronically (ASC X12N 837 Institutional).

- *UB-04 claims.* The POA indicator is reported on the eighth digit of Field Locator (FL) 67, principal diagnosis, and on the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q.

- *ASC X12N 837 Institutional (837I).* The POA indicator is reported in segment HI in the 2300 loop, data element C022-09.

16. What are the POA indicator codes?

The valid POA indicator codes are:

- *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 the condition was present at the time of inpatient admission
- *Blank* - Unreported/not used. Diagnosis is exempt from POA reporting

17. What are the POA indicator codes that trigger the payment adjustment?

The POA indicator codes that may affect payment are: "N" (not present on admission) and "U" (unable to determine presence on admission).

18. What happens to the claim if a POA indicator code is missing or has an invalid value?

The claims processing system will be enhanced to accept, edit and store POA indicator values, which will be used in identifying health care-acquired conditions. Claims will be denied for missing or invalid POA indicator codes where applicable. If the diagnosis is exempt from POA reporting, then it is acceptable to leave the field blank.

For the official guidelines on the list of diagnoses exempt from reporting, please see the *ICD-9-CM Official Guidelines for Coding and Reporting* at http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

HEALTH CARE-ACQUIRED CONDITIONS

19. How were the specific health care-acquired conditions (HCACs) selected?

The Affordable Care Act specified that health care-acquired conditions mean the medical conditions identified as the Medicare hospital-acquired conditions or HCACs. The law allows CMS to exclude certain conditions if it finds that the conditions do not apply to Medicaid beneficiaries. To date, only one condition exists that specifically excludes pediatric and obstetric populations (see question 9).

20. What are the specific health care-acquired conditions (HCACs)?

The full list of Medicaid HCACs is based on the list of Medicare HACs for FFY 2012 and consists of twelve conditions:

1) Foreign object retained after surgery
2) Air embolism
3) Blood incompatibility
4) Catheter associated urinary tract infection
5) Pressure ulcers stage III and IV (decubitus ulcers)
6) Vascular catheter associated infection
7) Mediastinitis, after coronary artery bypass graft (CABG)
8) Falls and trauma, resulting in fractures, dislocations, intracranial injury, crushing injury, burns and other unspecified effects of external causes
9) Manifestations of poor glycemic control
10) Surgical site infection after spine, neck, shoulder, or elbow orthopedic procedures
11) Surgical site infection after bariatric surgery for obesity
12) Deep vein thrombosis and pulmonary embolism after total knee replacement or hip replacement , except for pediatric (individuals under the age of 21) and obstetric populations

21. How frequently is the list of Medicaid HCACs updated?

The list of Medicaid HCACs will be updated annually based on the Medicare HAC list or other federally required changes specific to Medicaid. The Medicare HACs list is published October 1 each year with the

Medicare Inpatient Prospective Payment System final rule. DHCF will notify hospitals of any changes to the list of Medicaid HCACs, if appropriate.

ERRONEOUS SURGERIES

22. What are the erroneous surgeries or other invasive procedures?

In addition to the Medicaid HCAC list, the CMS final rule requires Medicaid programs to adopt the Medicare nonpayment policy regarding erroneous surgeries or other invasive procedures. This policy is specified in the three Medicare National Coverage Determination (NCD) memoranda on the coverage of erroneous surgeries on Medicare patients. These wrong procedures or OPPCs are commonly known as "never events" or "adverse events" that cause serious injury and/or death to a patient and are largely preventable.

DHCF payment policy for these services is based on the Medicare NCDs. Essentially, these procedures are not covered when the practitioner erroneously performs: 1) the wrong procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

23. Are providers required to report erroneous surgeries or other invasive procedures on Medicaid claims?

Yes. (See question 5 for applicable providers)

24. What codes are used to indicate an erroneous surgery or other invasive procedure?

Hospital inpatient and outpatient providers should report wrong procedures using the following diagnosis codes in the fields provided for event codes:

- E876.5 - Performance of wrong operation (procedure) on correct patient
- E876.6 - Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 - Performance of correct operation (procedure) on wrong side/body part

In addition, facilities and practitioners should also report wrong procedures using the following CPT/HCPCS modifiers associated with the surgical procedure:

- PA - Surgical or other invasive procedure on wrong body part
- PB - Surgical or other invasive procedure on wrong patient
- PC - Wrong surgery or other invasive procedure on patient

25. How will payment be affected if an erroneous surgery or other invasive procedure is performed?

Claims indicating any one of the three erroneous surgeries or procedures will be reviewed and denied if appropriate. DHCF may request additional information (e.g., medical records for admissions and/or outpatient procedures) from the provider to verify the occurrence or absence of an erroneous procedure. If it is determined that the wrong surgery was performed, no payment will be made for these services and services directly related to the wrong surgery.

26. What services are considered "related services" under the nonpayment of a wrong surgery?

The CMS final rule requires Medicaid programs to adopt the Medicare nonpayment policy regarding wrong surgeries. DHCF will follow Medicare's nonpayment policy specified in the three Medicare NCD memoranda and associated transmittals which describe "related services" (reprinted below).

- Related services do not include performance of the correct procedure.
- All services provided in the operating room when an error occurs are considered related and therefore not covered.
- All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment.
- All related services provided during the same hospitalization in which the error occurred are not covered.
- Following hospital discharge, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

For additional information on Medicare's policy for wrong surgeries, please see Medicare's transmittal at http://www.cms.gov/transmittals/downloads/R102NCD.pdf

27. Can the hospital or practitioner bill the Medicaid beneficiary when Medicaid denies payment for the wrong procedures?

No.

FURTHER INFORMATION AND CONTACTS

28. Where can I go for more information?

- *FAQ.* Updates of this document will be available on the DHCF website at www.dc-medicaid.com.

  Provider training sessions. Provider trainings will be held at Xerox State Healthcare, 750 1st Street NE, 9th floor conference room, Washington, DC, 20002 on the following dates:

  - Thursday, May 31, 2012, from 1:00 pm – 3:00 pm
  - Monday, June 4, 2012, from 1:00 pm – 3:00 pm
  - Friday, June 8, 2012, from 1:00 pm – 3:00 pm.
  - Tuesday, June 26, 2012, from 1:00-3:0pm.

  Please respond to Andrea L. Jackson at 202-906-8308, or by email at dc.providerreps@acs-inc.com, if planning to attend.

- *Provider billing manuals.* The provider billing manuals will be updated to reflect the POA, HCAC, and OPPC erroneous surgeries payment policy. Provider billing manual updates will be available at www.dc-medicaid.com.

- *Useful links.* Providers may find other helpful sources of information:

Medicaid regulations and other guidance from CMS:
http://www.medicaid.gov/AffordableCareAct/Provisions/Quality-of-Care-and-Delivery-Systems.html

Medicare regulations and fact sheets on hospital-acquired conditions from CMS:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html

Educational materials from other Medicaid programs:
http://www.indianamedicaid.com/ihcp/bulletins/bt200928.pdf

http://www.tmhp.com/News_Items/2010/08-13-10%20Present%20on%20Admission%20Reporting.pdf

29. Who do I contact for more information?

Policy questions:	Claudia Schlosberg, Director Health Care Policy & Research Administration Claudia.schlosberg@dc.gov
Billing and payment questions:	Provider Inquiry (202) 906-8319 (inside DC metro area) (866) 752-9233 (outside DC metro area)