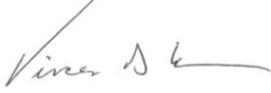




ISSUE DATE June 15, 2012	EFFECTIVE DATE July 1, 2012	NUMBER *See Below
SUBJECT Provider Preventable Conditions		BY  Vincent D. Gordon, Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this Medical Assistance (MA) Bulletin is to inform providers of the MA Program’s payment policy and reporting requirements for Provider Preventable Conditions effective July 1, 2012.

SCOPE:

This bulletin applies to the following enrolled providers that provide services to MA recipients enrolled in the Fee-For-Service delivery system, including ACCESS Plus:

- Acute care general hospitals paid under the prospective payment system;
- Inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals paid under the prospective per diem system;
- Nursing facilities, including private, county and state operated nursing facilities paid under the prospective per diem system;
- Intermediate care facilities for the intellectually disabled (ICF/ID) or other related conditions (ICF/ORC) paid under the prospective per diem system;
- Ambulatory surgical centers and hospital based short procedure units paid from the MA Program Fee Schedule;
- Clinics, including hospital based medical –surgical clinics, independent medical-surgical clinics, and family planning clinics paid from the MA Program Fee Schedule;
- Rural health clinics, federally qualified health centers and birth centers paid under a prospective payment rate; and
- Practitioners, including physicians, dentists, podiatrists, certified registered nurse practitioners, optometrists and midwives paid from the MA Program Fee Schedule.

*01-12-30	03-12-27	09-12-32	18-12-01	31-12-32	33-12-31
02-12-27	08-12-30	14-12-27	27-12-28	32-12-27	47-12-01

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/index.htm>

Providers rendering services under the MA managed care delivery system should address any questions related to payment policy and reporting requirements to the appropriate managed care organization (MCO).

BACKGROUND:

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) (ACA), enacted March 23, 2010, required the United States Department of Health and Human Services (HHS) to promulgate regulations that prohibit payment by State Medicaid Programs for health care-acquired conditions (HCACs), effective July 1, 2011.

On June 6, 2011, the Centers for Medicare and Medicaid Services (CMS), the agency within HHS that administers the Medicare program and works in partnership with states to administer Medicaid programs, established an umbrella term of provider preventable conditions (PPCs), which encompasses HCACs and other provider preventable conditions (OPPCs), and promulgated regulations regarding Medicaid program payment prohibitions for PPCs. While the statutory effective date is July 1, 2011, CMS delayed compliance action on these provisions until July 1, 2012. (See Federal Register (FR), Vol.76, No. 108, 32816-32838).

A HCAC is defined as “a condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition (HAC) by the Secretary of HHS under section 1886(d)(4)(D) of the Social Security Act (Act), other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients”. The list of Medicare HACs for Fiscal Year 2011 follows:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and Stage IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Other injuries
- Manifestations of Poor Glycemic Control
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemia Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity

- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Surgical Site Infection following:
 - Coronary Artery Bypass Graft – Mediastinitis
 - Bariatric Surgery
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
 - Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
 - DVT/PE
 - Total Knee Replacement
 - Hip Replacement

Section 5001(c) of the Deficit Reduction Action provides for the revision of the list of (HAC) conditions from time to time. (See FR, Vol. 76, No. 160, 51476-51846).

An OPPC is defined as “a condition occurring in any health care setting that meets the following criteria:

- is identified in the state’s Medicaid State Plan;
- has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- has a negative consequence for the beneficiary;
- is auditable;
- includes, at a minimum,
 - wrong surgical or other invasive procedure performed on a patient;
 - surgical or other invasive procedure performed on the wrong body part; and
 - surgical or other invasive procedure performed on the wrong patient.

A state’s Medicaid State Plan must prohibit payment for PPCs, including Medicaid payments for services received by individuals dually eligible for Medicare and Medicaid. The state must ensure that the non-payment for PPCs does not prevent access to services for its Medicaid recipients. Additionally, a state’s Medicaid State Plan must require that providers identify PPCs that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid recipients for which Medicaid program payment is otherwise available.

A state may not reduce a MA payment to a provider for a PPC if the PPC existed prior to the initiation of treatment of the patient by that provider. Further, a state is required to reduce payments only to the extent that the PPC results in an increased payment to the provider and the portion of the payment directly related to treatment for, and related to the PPC can be reasonably isolated. Finally, Federal Financial Participation (FFP) will not be available for state expenditures for PPCs.

The Department of Public Welfare (Department) is committed to ensuring that quality health care is provided to eligible MA recipients in all healthcare settings. Although not specifically naming PPCs as such services, the Department has long prohibited payment for services that are harmful to recipients, of inferior quality or medically unnecessary. More specifically, the MA Program has the following relevant payment limitations:

- 62 P.S. 1407 (a)(6) and 55 Pa.Code §1101.77(a)(10) prohibits the submission of claims for the provision of MA services which the Department's medical professionals have determined to be harmful or of little or no benefit to the recipient , of inferior quality, or medically unnecessary;
- 55 Pa.Code §1101.71 relating to utilization control sets forth the MA Program's responsibility to establish procedures for reviewing the utilization of and payment for, MA services in accordance with section 1902(a)(3) of the Act (42 U.S.C.A. §1396a(a)(30)) as well as the provider's responsibility to cooperate with such reviews;
- 55 Pa.Code § 1101.83 relating to restitution and repayment, sets forth the Department's right to restitution for noncompensable services; and 55 Pa.Code §1150.61 relating to general payment policy, sets forth that the Department will pay for covered services that comply with applicable regulations.

On September 30, 2011, the Department submitted a State Plan Amendment (SPA) to the CMS assuring compliance with the federal statutory requirements for non-payment of PPCs. Upon CMS approval of the SPA, the Department will implement the provision for prohibition of payment for PPCs, i.e., HCACs and the required OPPCs, which consist of the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, and surgical or other invasive procedure performed on the wrong patient.

PROCEDURE:

In order to comply with the above federal and state statutory requirements and MA Program payment regulations, providers are required to report PPCs, including HCACs and OPPCs on or attached to their claims to the Department.

The Department will adjust provider payments for HCACs and OPPCs in accordance with federal and state statutory requirements and MA Program payment regulations in the following manner:

Health Care Acquired Conditions (HCACs)

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals must report a "Present On Admission" (POA) indicator for each diagnosis code on their claim(s). POA indicators include the following:

- Y – described as "Diagnosis was present at the time of inpatient admission".
- N – described as "Diagnosis was not present at the time of inpatient admission".
- U – described as "Documentation insufficient to determine if condition was present at the time of admission".
- W – described as "Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission".
- Blank - described as "Exempt from POA reporting" (electronic or internet claims, must be reported with POA Exempt Diagnosis).
- 1 – described as "Exempt from POA reporting" (paper claims only, must be reported with POA Exempt Diagnosis).

Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs by using the applicable POA indicator on their claims. Additionally, rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to report HCACs through the Department's Concurrent Hospital Review (CHR) Process.

The Department will exclude any HCAC diagnosis code or HCAC diagnosis code/procedure code combination associated with the applicable POA indicator from grouping of the acute care general hospital's inpatient claim. The Department then will be able to reasonably isolate costs associated with the HCAC and thereby ensure that the hospital receives the appropriate All Patient Refined-Diagnosis Related Group (APR-DRG) payment and does not receive payment for a higher paying APR-DRG or an APR-DRG with a higher severity level.

The Department will deny days associated with HCACs and reduce the number of inpatient covered days by the denied number of days on inpatient rehabilitation and psychiatric hospitals' and excluded rehabilitation and psychiatric units of acute care general hospitals' inpatient claims, as determined through physician review under the Department's CHR process and as reported by the POA indicator on the claim.

Other Provider Preventable Conditions (OPPCs)

When an OPPC occurs, acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are required to complete the OPPC Self Reporting Form (MA 551) according to

directions and submit the form as an attachment to their claim following the directions for submitting a claim attachment according to the applicable provider's billing guidelines. Acute care general hospitals and inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals are reminded that they must identify all practitioners involved and provide details relating to the OPPC event.

The Department developed a new claims processing edit to post on inpatient claims when one or more of the following diagnosis codes are indicated on the OPPC Self Reporting attachment to the claim:

- E8765 defined as "Performance of wrong operation (procedure) on correct patient";
- E8766 defined as "Performance of operation (procedure) on patient not scheduled for surgery"; or
- E8767 defined as "Performance of correct operation (procedure) on wrong side/body part".

The Department will manually review acute care general hospital claims to determine whether the identified OPPC will result in a higher APR-DRG or increases the severity associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly. If the acute care general hospitalization is solely the result of an OPPC that occurred upon admission, the Department will not make an APR-DRG payment to the hospital.

The Department will not make a per diem payment to inpatient rehabilitation and psychiatric hospitals and excluded rehabilitation and psychiatric units of acute care general hospitals when an OPPC is reported with the claim as denied through the CHR process.

All other providers are required to report the applicable procedure code(s) with one or more of the following modifiers on the claim when an OPPC occurs:

- PA defined as "Surgical or other invasive procedure on the wrong body part"
- PB defined as "Surgical or the invasive procedure on the wrong patient"
- PC defined as "Wrong surgery or other invasive procedure on the patient".

The Department will deny the nursing facilities', county nursing facilities', ICF/IDs', and ICF/ORCs' per diem payment when an OPPC is reported on the claim.

The Department will deny the ambulatory surgical centers', hospital short procedure units', clinics', and practitioners' MA Fee Schedule payment when an OPPC is reported on the claim. In instances when an OPPC occurs during an operation involving multiple surgical procedures, anesthesiologists are to submit separate claims and adhere to the following instructions:

- Submit a claim and report the anesthesia time (in minutes) associated with the procedure code that **is not related** to the OPPC.
- Submit another claim and report the anesthesia time (in minutes) associated with procedure code and applicable modifiers PA, PB, and/or PC that **are related** to the OPPC.

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) that provide dental services are to report OPPCs using modifiers PA, PB, and/or PC in the “Remarks” section of the ADA claim form or in the “Billing Note” of the electronic dental (837-D) or Internet dental claim media. The Department will deny the RHC’s and FQHC’s prospective payment when an OPPC is reported on the claim.

MA recipients and/or their families are held harmless and the provider and/or facility are not permitted to bill the MA recipient or their families for PPCs, which includes the billing of any applicable MA copayment, deductible or coinsurance amount.

Providers are required to report PPCs to the Department as directed in their MA Program Provider Handbooks. Providers are to refer to updates in their Billing Guides regarding claim submissions for PPCs, including HCACs and OPPCs. MA Program Provider Handbooks and Billing Guides may be viewed by accessing the following website link: <http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>.

Providers may download the OPPC Self Reporting Form by accessing the following website link: <http://www.dpw.state.pa.us/findaform/ordermedicalassistanceforms/index.htm>

ATTACHMENT:

[OPPC Self-Reporting Form and Completion Instructions \(MA 551\)](#)