OMB No.: 0938-1136

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act

Payment Adjustment for Provider Preventable Conditions:

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903of the Social Security Act with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(B)

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

__NA__ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

Healthcare Acquired Conditions (HACs)

a. Payment adjustment methodology: payments for HAC claims will be adjusted as follows:

Effective with dates of service on or after September 1, 2012, all inpatient hospital claims with ICD diagnosis codes* indicating potential HACs, as identified by Medicare, other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism(PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients, will be processed as follows:

- *If the claim POA indicator is **Y** - Diagnosis was present at time of inpatient admission - IDAHO MEDICAID **will pay** for all services as usual, including those selected HACs that are coded with a POA indicator of "**Y**".*

- *If the claim POA indicator is **N** - Diagnosis was not present at time of inpatient admission - IDAHO MEDICAID **will not pay** for services with HACs that are coded with a POA indicator of "**N**". All other services not identified as HACs will be paid as usual.*

- *If the claim POA indicator is **U** - Documentation insufficient to determine if the condition was present at the time of inpatient admission - IDAHO MEDICAID **will not pay** for services with HACs that are coded with a POA indicator of "**U**". All other services not identified as HACs will be paid as usual.*

- *If the claim POA indicator is **W** - Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission - IDAHO MEDICAID **will pay** for services as usual, including those selected HACs that are coded with a POA indicator of "**W**".*

*The ICD-9 codes used by Idaho Medicaid are the same codes used by Medicare for hospital acquired conditions.

Providers must split their claims when a claim with a HAC condition has an indicator of N or U. If Medicaid receives claims that need to be split, the claim will be denied with an EOB instructing the provider to split and resubmit the claim.

Idaho Medicaid's inpatient hospital providers are paid a percentage of their per diem and ancillary charges (except for lab and imaging services) based on a methodology using each hospital's Cost Audit Settlement history. Specific lab and imaging services are paid a statewide fee-for-service amount.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above. HAC claims identified by Quality Improvement Organization review, program integrity and fraud control efforts, third party insurance carrier, or other means will be not be paid.

a. Regulatory Assurances – In compliance with 42 CFR 447.26(c), the State provides:

a. That no reduction in payment for a Healthcare Acquired Condition (HAC) will be imposed on a provider when the condition defined as a HAC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

b. That reductions in provider payment may be limited to the extent that the following apply:
   i. The identified HAC would otherwise result in an increase in payment.
   ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the HAC.

c. Assurance that non-payment for HACs does not prevent access to services for Medicaid beneficiaries.

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Attachment Page 4.19B – Other Provider Preventable Conditions (OPPCs):

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 of the Social Security Act with respect to non-payment for OPPCs:

The State identifies the following OPPCs for non-payment under Section(s) 4.19(B):

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient.

a. Payment adjustment methodology: payments for OPPC claims will be adjusted as follows:

i. For hospital outpatient, ASCs, practitioner, and all appropriate TOBs for claims with dates of service on or after September 1, 2012, providers must append one of the following applicable HCPCS modifiers to all lines related to the surgical error.

PA: Surgery or other invasive procedure performed on the wrong body part
PB: Surgery or other invasive procedure performed on the wrong patient
PC: Wrong surgery or other invasive procedure performed on patient

ii. Hospitals must submit the non-covered type of bill code 110, and include in the Remarks Section one of the following 2 digit Surgical Error Codes:

MX - Wrong surgery on patient
MY –Surgery on wrong body part
MZ – Surgery on wrong patient

The MMIS system is set up to automatically deny claim details billed with these codes. Manual review may be required to find related claims if the providers did not code their claims correctly. In these cases, any claims related to the HAC and/or OPPC conditions will be researched to find any related charges and the claims will be non-payable (if pending), or recouped (if paid) from the provider and reported to the Medicaid Program Integrity Unit.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

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b. Regulatory Assurances – In compliance with 42 CFR 447.26(c), the State provides:

i. That no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

ii. That reductions in provider payment may be limited to the extent that the following apply:

- The identified provider preventable conditions would otherwise result in an increase in payment.
- The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

iii. Assurance that non-payment for provider preventable conditions does not prevent access to services for Medicaid beneficiaries.