

Provider Preventable Conditions Frequently Asked Questions

Effective Date

Q1. The final rule on Medicaid Payment Adjustment for Provider-Preventable Conditions, Including Health Care-Acquired Conditions, was issued on June 6, 2011. In the preamble to the rule, CMS indicated that, while the regulations are effective July 1, 2011 (consistent with the statutory effective date), CMS intends to delay compliance action on these regulations until July 1, 2012. Regarding this delay, are states required to submit the SPA to be effective July 1, 2011, or may the SPA be submitted to correspond to the July 1, 2012 compliance date?

A1. The regulations are effective July 1, 2011, in accordance with the statute. In order to be in compliance with the law, States would need to submit State plan amendments no later than September 30, 2011.

We state in the preamble to the final rule that we would not take compliance action against States under the provider-preventable conditions (PPC) rule until July 1, 2012. We did so noting that States may need additional time to develop and complete the implementation of sound PPC policies. This delay in CMS compliance action is not the same as authorizing States to delay submitting conforming State plan amendments. We expect that States will submit such amendments to CMS, but recognize that States may face unavoidable delays as the new policies are communicated to providers and implemented through the State's claims processing systems.

Q2. Do public notice and public process requirements apply to these provisions? What if a State is only adopting the minimum requirements under the statute and implementing regulation?

A2. Yes, this is a reimbursement change and requires that notice or public process be followed even if the State is adopting the minimum requirements under the statute and implementing regulations. States should note that these minimum requirements are not identical with the Medicare requirements. If a State wants to adopt the Medicare requirements, then it would have to make a finding to include the DVT/PE pediatric and obstetric exclusion (447.26 (b)(ii)).

Providers Impacted by State PPC Payment Provisions

Q3. Medicare's HACs policy only applies to Medicare inpatient prospective payment system (IPPS) hospitals. Does Medicaid's Health Care-Acquired Conditions (HCAC) category apply only to IPPS hospitals? What about Critical Access Hospitals (CAH)?

A3. Under Medicaid, States must deny payments in any inpatient hospital setting for the identified PPCs. This includes Medicare's IPPS hospitals, as well as other inpatient hospital settings that may be IPPS exempt under Medicare, or that States identify as inpatient hospital settings in their Medicaid plans. This also includes CAHs that operate as inpatient hospitals.

Q4. Do these provisions apply to payments made to out-of-State providers?

A4. Yes, State payments to out-of-State providers are subject to approved State PPC non-payment policies.

Medicare Cross Over Claims

Q5. Please clarify what is required of states in order to prevent payment for a Medicare-denied claim based on a “HAC” by working with Medicare FIs.

A5. We have had ongoing discussions with our partners in Medicare to identify simple ways for States to limit third party liability for cross over claims related to Medicare HACs. Based on those conversations, the best mechanism continues to be state review of Medicare and Medicaid claims that indicate the occurrence of PPCs. States may use the codes identified on the Medicare website at:

Q6. The final rule at 42 C.F.R §447.26 addresses situations that may arise with hospitals that are exempt under Medicare rule but not exempt under Medicaid rule. If a claim is paid by Medicare to a hospital that is exempt under Medicare, Medicaid will receive the cross-over claim from Medicare with the coinsurance and deductible amount indicated. Because those hospitals are exempt from Medicare nonpayment review, the hospitals may not report the present-on-admission (POA) data element. As a result, the Medicare paid claim that comes to Medicaid will not have POA indicators, and Medicaid would not be able to determine if the Medicaid POA exception from nonpayment is applicable. Will Medicaid be required to apply a reimbursement reduction even though Medicare will not identify a condition on the cross over claim; or will Medicaid be responsible for ensuring that all providers subject to States’ PPC policies, including those exempt from Medicare’s HAC policy be required to indicate the occurrence of a PPC regardless of their intention to bill?

A6. The absence of POA indicators on Medicare cross over claims does not exempt States from applying PPC payment reductions, for Medicaid beneficiaries or individuals dually eligible for both Medicare and Medicaid when the provider has not documented a POA condition. 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. To the extent that Medicaid payment is claimed (either directly or indirectly), in order to document the provider’s claim, the provider should include in that identification the POA status. States will need to work with all affected provider types to ensure proper documentation of provider claims..

Payment Adjustments

Q7. Since providers will bill States for services, is the portion of the payment for the PPC denied or is the entire claim denied? How does it work? Providers will then report the PPC, correct?

A7. How payments are reduced will depend on how States design their payment reductions. Reductions in provider payment may be limited to the extent the PPC causes an increase in the payment amount, and the State can determine specific increased amounts related to the PPC.

For instance, if a patient goes in for a coronary artery bypass (open heart surgery) and develops mediastinitis (a post operative infection occurring on the bone in front of the heart), the State will only be permitted to reduce payment by amounts related to the mediastinitis, not the initial open heart surgery, to the extent that it can reasonably isolate those amounts. States will have flexibility in determining how payment adjustments will be made, but CMS will have to approve the methodology. Providers will report the PPC to the State whether or not a claim is submitted.

Q8. Would CMS approve a state plan whereby a claim involving a PPC is flagged prior to payment and the services related to the PPC is removed prior to the claim being used for the next year’s rate development? The claim would be identified, the lines related to the PPC would be denied and therefore would produce the lower the APR-DRG for that stay and then that lowered APR-DRG would be utilized for the rate development for the next year, where the actual decrease in payment would then be captured.

A8. We cannot confirm whether CMS would approve any payment methodology without having fully reviewed the details of the State’s proposal. The rule requires that reduction in provider payment is required only if the PPC results in an increase in payment. While the question makes clear that costs

related to the PPC would be removed from the rate determination for future years, it is not clear whether payment in the current year would reflect the PPC. The question highlights the issue of whether the nonpayment requirement includes both direct payments and indirect payments that may result from the use of the costs of PPCs in calculating future payment rates, or in measuring uncompensated care. We interpret the nonpayment requirement to apply in both situations and will be working with States to ensure that the costs of PPCs, related services, or other medical errors are excluded from a base rate before developing a payment year rate, and are not counted as uncompensated care.

Q9. Would CMS allow a methodology that denies payment for an entire stay when a PPC is identified? The rule requires reductions in provider payment may be limited to the extent that the identified provider preventable conditions would otherwise result in an increase in payment; and the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions. Additionally, the Statute and regulations require that payment adjustments for provider preventable conditions may not impact beneficiary access to care.

A9. A State could not deny provider payment for covered high quality care otherwise received during an inpatient hospital stay to the extent that the State can reasonably isolate the portion of the payment related to the PPC.

Q10. In a situation where chronic disease and rehabilitation hospitals are reimbursed facility specific per diem rates derived from allowable reported costs in the base year, would CMS approve a state plan where, for claims submitted in which there is a PPC diagnosis that was not present on admission, the State would flag those claims and adjust the base year costs by removing the service costs associated with the PPC? Future rates would be adjusted to remove the cost of the PPC at the point in which the base year used to derive the per diem rates is the year in which the PPC occurred.

A10. We cannot confirm whether CMS would approve any payment methodology without having fully reviewed the details of the State's proposal. We agree that costs associated with a PPC should be removed from calculation of base year costs used for calculation of future rates. But it is not clear in the example whether hospital days that are attributable only to the PPC would be paid in the non-base years.

Q11. Does the impact of the PPC on the cost basis only occur if and when the base year is updated or would the existing base year be adjusted by PPC services costs and recalculated on the next rate review? Is action necessary only if the costs associated with the PPCs resulted in an increase in allowable costs which leads to an increase in payment?

A11. The payment adjustment will largely depend on the State's payment system. Nonpayment is only required when the PPC results in an increase in provider payment, whether direct or indirect.

Q12. Would CMS be in agreement with a plan, with a per diem type methodology, that allows only room/board type payment for a PPC claim? Or some type of non-payment for the entire stay until the hospital provides evidence that the condition is corrected?

A12. If the PPC is the sole reason for a portion of an inpatient stay, then no payment may be made for that portion of the stay (which would include necessary room and board for that portion of the stay).

The rule does not limit States' ability to design other value based payment structures that would encourage providers to take specific action to mitigate medical errors.

Q13. Never event, physician-caused: If the "never event" is attributable to a physician only and the facility is not at fault, can we recover from the physician and not the facility?

A13. The terminology is always very confusing, so we will use HCACs and OPPCs to be consistent with the Medicaid final rule. For HCACs, the conditions that are identified for non-payment in the inpatient hospital setting under Medicaid, the Statute authorizes an adjustment to the inpatient hospital rate when there is an increase in cost related to the HCAC. HCACs do not apply directly to physician services that are separately billable or reimbursed under Medicaid. States can identify additional OPPCs that meet the requirements under the final rule. This means that a State could elect to identify a particular HCAC for non-payment under its physician reimbursement section and reduce physician payment related to those services as allowable under the rule.

OPPCs were adopted from Medicare's National Coverage Determinations that deny payment for the wrong surgery or invasive procedure performed, the correct surgery performed on the wrong patient, or the correct surgery performed on the wrong site, as well as the related procedures. Consistent with Medicare's policy for these conditions, States should deny payment for these events as well as the related services during a hospital stay where the event occurred. All services provided in the operating room when an error occurs are considered related and therefore not reimbursable. 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 reimbursable. Additional guidance regarding non-payment for the minimum OPPCs can be found at: <http://www.cms.gov/Transmittals/downloads/R102NCD.pdf>. There are also detailed and helpful resources at:
<https://www.cms.gov/MLNMattersArticles/downloads/MM6405.pdf> and
<http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf>.

Q14. Non-payment beyond the event: Is non-payment only applicable to the hospital stay or procedure during which the PPC occurred? For instance, a PPC necessitates at-home wound care following the hospitalization. Would payment be denied for that, if provided by the hospital causing the PPC?

A14. For HCACs payment adjustments are made when a condition is determined to be not present on admission, but present at discharge, being obtained during the course of care at the hospital. If the patient were to present at another provider, the condition would be present on admission and not subject to the payment adjustment. States are not precluded from developing reimbursement methodologies that consider other adjustments or disincentives for error related courses of care, but those policies are outside the scope of the PPC policy. This would require that State amend its plan and work with CMS to develop the appropriate methodologies in compliance with the broader Medicaid reimbursement guidelines.

As stated earlier, the minimum OPPCs were adopted from Medicare's National Coverage Determinations that deny payment for the wrong surgery or invasive procedure performed, the correct surgery performed on the wrong patient, or the correct surgery performed on the wrong site, as well as the related procedures. The policy articulated by Medicare includes related services for the particular hospitalization, however, any covered and appropriate care provided after discharge can be reimbursed as appropriate under the program. Additional guidance regarding non-payment for the minimum OPPCs can be found at:

<http://www.cms.gov/Transmittals/downloads/R102NCD.pdf>.

There are also detailed and helpful resources at:

<https://www.cms.gov/MLNMattersArticles/downloads/MM6405.pdf> and

<http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf>.

Length of Stay Requirements

Q15. For hospitals with long lengths of stay and the condition is not present on admission (POA), what if a PPC occurs months/years after admission?

A15. The rules require no reduction in payment for a PPC when the condition existed prior to the initiation of treatment for that patient by that provider. The rules do not provide exceptions based on length of stay. The required reduction of payment would be limited, however, to the extent that the State can reasonably isolate the portion of the payment related to the PPC.

Provider Reporting

Q16. Do hospitals need to submit a separate report of an HAC or National Coverage Determination (NCD) event to the Medicaid agency or would the edits in the MMIS system be enough to flag the event for identification and action?

A16. The rule requires that States require providers identify the occurrence of a PPC associated with a Medicaid patient regardless of the provider's intention to bill for that event. We are working with our MMIS redesign team to ensure that States have a consistent platform for provider reporting of PPCs.

Q17. Please clarify provider reporting requirements. CMS comments in preamble to final rule that providers need to report but also states that "existing claims systems can be used as a platform for self-reporting". Other comments say that "ultimately the provider will self-report the PPCs to the state; the state may choose to verify this by a POA or 'other method.'"

A17. The rule requires that States require providers identify the occurrence of a PPC associated with a Medicaid patient regardless of the provider's intention to bill for that event. We are working with our MMIS redesign team to ensure that States have a consistent platform for provider reporting of PPCs.

Q18. In what format should the report to CMS be made? With what frequency?

A18. The rule requires that States require providers identify the occurrence of a PPC associated with a Medicaid patient regardless of the provider's intention to bill for that event. We are working with our MMIS redesign team to ensure that States have a consistent platform for provider reporting of PPCs.

States should anticipate reporting this information quarterly.

Q19. Provider self-reporting: What is meant by "The final rule requires that States revised Medicaid plans to comply with this provision and mandates that States implement provider self reporting through claims systems." The Q&A states: "The rule requires that States require providers identifying the occurrence of a PPC associated with a Medicaid patient regardless of the provider's intention to bill for that event. We are working with our MMIS redesign team to ensure that States have a consistent platform for provider reporting of PPCs." How is it recommended that states address this requirement by the compliance date?

A19. As stated in the final rule, we require that States implement reporting requirements through their provider claims systems. States are most familiar with their payment and claims systems and we urge States to work with their provider groups to determine the best means for implementing the provisions of the rule.

Q20. PPC Codes: Will a list of PPC codes be issued? We used Medicare's PPC list and created a list based on 2012 Ingenix ICD-9-CM. Our staff with nursing backgrounds recommended considering the following codes: under Surgical Site Infection, should the following codes be included: 81.30, 81.81, 81.84, and 81.88? Under DVT/PE, should the following code be included: 415.13.

A20. We do not intend to issue PPC codes beyond what Medicare has issued. We are working with our Systems Teams to ensure that we can better capture State codes for provider reporting purposes. As for the DVT/PE coding, we recommend that the State look to Medicare's coding guidance.

Appeals Processes

Q21. Does a separate appeals process need to be developed or may states use their standard claims appeal process?

A21. In the preamble to the final rule we advise that, "existing State appeal processes may be available for a provider to contest whether a State has improperly identified the occurrence of a condition identified as a PPC."

State Plan Requirements

Q22. What minimum set of conditions **must** States identify for non-payment under their Medicaid State plans?

A22. States must amend their State plans to deny payment for the following list of conditions in any inpatient hospital setting:

• Foreign Object Retained After Surgery
• Air Embolism
• Blood Incompatibility
• Stage III and IV Pressure Ulcers
• Falls and Trauma
○ Fractures
○ Dislocations
○ Intracranial Injuries
○ Crushing Injuries
○ Burns
○ Electric Shock
• Catheter-Associated Urinary Tract Infection (UTI)
• Vascular Catheter-Associated Infection
• Manifestations of Poor Glycemic Control
○ Diabetic Ketoacidosis
○ Nonketotic Hyperosmolar Coma
○ Hypoglycemic Coma
○ Secondary Diabetes with Ketoacidosis
○ Secondary Diabetes with Hyperosmolarity
• Surgical Site Infection Following:
○ Coronary Artery Bypass Graft (CABG) - Mediastinitis
○ Bariatric Surgery
✖ Laparoscopic Gastric Bypass
✖ Gastroenterostomy
✖ Laparoscopic Gastric Restrictive Surgery
○ Orthopedic Procedures
✖ Spine
✖ Neck
✖ Shoulder
✖ Elbow
• Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement – <i>with pediatric and obstetric exceptions</i>

States must amend their State plans to deny payment for the following conditions in any health care setting:

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| • 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 |

Q23. Can a State expand beyond the minimum requirements for conditions? For provider types? How?

A23. A State can expand beyond minimum requirements for identifying PPCs. The regulation defines two separate categories of PPC, Health Care-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). The conditions identified for the HCAC category are defined as Medicare's Hospital Acquired Conditions (HACs) and can only be changed as a result of a change to Medicare's HACs. States have no authority under these provisions to identify additional HCACs other than to update their Medicaid plans to reflect changes in Medicare HACs.

The conditions identified for the OPPCs category must include the wrong surgery, wrong site, or wrong patient events identified in the rule. However, States do have authority to identify additional OPPCs that occur in any health care setting in accordance with the regulations which require that additional OPPCs must be:

- a) identified in the State plan;
- b) have 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;
- c) of negative consequence for the beneficiary; and
- d) auditable.

If a State wants to expand its list of conditions, the State must:

1. identify conditions that meet the OPPC definition of the rule and make a finding, based upon a review of medical literature by qualified professionals, that a condition is reasonably preventable through the application of procedures supported by evidence-based guidelines;
2. revise its Medicaid State plan to identify the condition and the provider type/service setting on the pre-print; and
3. revise its Medicaid Reimbursement sections as necessary to indicate how provider payments will be adjusted.

Q24. Some States have existing programs that identify Medicare's full list of HACs without any pediatric and obstetric exceptions for Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement. Do these States need to revise their State plans to recognize the exclusion under Medicaid?

A24. States that exclude payment for Medicare's full list of HACs without pediatric and obstetric exclusions for Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement will need to indicate in their State plans that such conditions are

recognized as OPPCs,. States can use the PPC pre-print to make this amendment, and will need to amend reimbursement sections as necessary.

Q25. If a State has an existing program that identifies conditions beyond the minimum requirements, does the State need to include those conditions in its State plan?

A25. Yes. They would be identified as OPPCs (see response to question 19).

Q26. What if some of the conditions already identified in the State plan include conditions that apply in an inpatient hospital setting?

A26. As stated in response to question 19, States may recognize as OPPCs conditions that occur in any health care setting including inpatient hospitals.