

PROVIDER BULLETIN

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HEALTH CARE-ACQUIRED CONDITIONS INPATIENT HOSPITAL BULLETIN

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PROVIDER PREVENTABLE CONDITIONS

Provider Preventable Conditions (PPC) is an umbrella term established by the Centers for Medicare and Medicaid Services (CMS) for hospital and non-hospital acquired conditions identified by the State for nonpayment to ensure the high quality of Medicaid services. PPCs include two distinct parts, Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), otherwise known as Adverse Events. The CMS has mandated that state Medicaid agencies implement policies and procedures for reporting, review and, if appropriate, nonpayment or payment recoupments for services designated as a provider preventable condition by July 1, 2012. Additional information regarding PPCs can be found in the Federal Register, Vol. 76, No. 108, dated June 6, 2011 and Missouri state regulation 13 CSR 70-3.230. Information regarding MO HealthNet billing procedures for OPPCs can be found in the Adverse Events Bulletin, Volume 33, Number 34 dated February 8, 2011.

HEALTH CARE-ACQUIRED CONDITIONS

Health Care-Acquired Conditions (HCAC) are conditions that could reasonably have been prevented by the health care establishment, as well as through implementation of appropriate policies, procedures and protocols by a hospital. In accordance with the Federal Register, Vol. 76, No. 108, dated June 6, 2011, HCACs for state Medicaid agencies apply only to the inpatient hospital setting and are defined as the full list of Medicare's Hospital-Acquired Conditions, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients. A complete list of diagnosis and diagnosis/procedure combinations currently designated as HCACs is attached to this bulletin and can be found in Missouri state regulation 13 CSR 70-3.230. A list of Medicare's Hospital-Acquired Conditions is available on the CMS Web site at cms.gov/HospitalAcqCond/.

To meet the CMS mandated requirements, MO HealthNet providers are required to report all HCAC diagnosis codes to the MO HealthNet Division (MHD). Providers will report this information by entering the appropriate Present On Admission (POA) indicator for all diagnosis codes submitted on their claims. The HCAC diagnosis code and the corresponding POA indicator must be populated within the first five (5) diagnosis positions on the inpatient claim. Present On Admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter prior to an admission to inpatient, including emergency department, observation or outpatient surgery, are considered as Present On Admission.

The POA indicator will be required for all diagnosis codes submitted on claims when the last date of service billed is on or after July 1, 2012, excluding those diagnosis codes designated under the ICD-9-CM Official Guidelines for Coding and Reporting as exempt from the POA requirement. Claims containing an invalid or missing POA indicator will be denied unless the diagnosis is exempt from the POA requirement. Use the UB-04 Data Specifications Manual and the ICD-9-CM Official Guidelines for Coding and Reporting for proper assignment of the POA indicator. Valid POA indicator values are:

Y = Yes – present at the time of inpatient admission.

N = No – not present at the time of inpatient admission.

U = Unknown – documentation is insufficient to determine if condition is present on admission.

W = Clinically undetermined – provider is unable to clinically determine whether condition was present on admission or not.

As stated above, CMS and state regulation require MO HealthNet to capture and review claims data, as well as medical records when appropriate, for services billed with a HCAC diagnosis that was not present at the time of admission. The state regulation authorizes MO HealthNet to reduce or recoup claim payment if the condition is considered preventable, resulted in additional hospital services not otherwise needed, and/or lengthened the hospital stay. If one of your claims has indicated a HCAC with a POA indicator of “N”, the MHD may request a copy of the medical record for a post payment review.

PROVIDER SELF REPORTING

Additional system work is currently underway to allow hospitals to self report days associated with HCACs as non-covered on the inpatient claim. Any claim in which the hospital self reports non-covered days will not be included in the post payment review process explained above. The non-covered days indicated on the claim will not be paid by MO HealthNet. The system work to properly process claims with non-covered days should be completed this fall.

Once the system work is complete, another bulletin will be released explaining how to properly report the non-covered days on the inpatient claim. If providers identify days as associated with a HCAC before the system work is complete, they can hold their claims until the explanatory bulletin is released. At that point the claim(s) can be submitted reflecting any designated non-covered days, and the claim will not be picked up in the MO HealthNet's post payment review process. Otherwise, providers can submit claims reflecting the entire stay, and the claim will be included in the post-payment review process.

Hospitals may also perform an internal post payment self-audit to identify any HCAC non-covered days. The hospital can then adjust any overpaid claim(s) to reflect the HCAC non-covered days once the system work is complete. Given timely notification, MO HealthNet will take measures to ensure those hospital adjusted claims are not included in the post payment audit.

HCAC AND INPATIENT CERTIFICATION REQUESTS

As part of MO HealthNet's effort to comply with the CMS and state regulations, effective July 1, 2012, the Present On Admission (POA) indicator will be required during the inpatient certification request process. The POA indicator must be provided for all HCAC diagnoses given at the time of an inpatient certification request and/or continued stay review. HCAC diagnoses with a POA indicator of "N" will require the date of onset of that condition for the certification request to be accepted. The date of onset must be after the date of admission and prior to date of discharge, if the discharge date is known at that time. MO HealthNet is only expecting information that is known at the time the initial or continued stay review request is made. Inpatient certification requests containing the required information will process in the same manner as they do today, and the information provided will not affect the benchmark length of stay assigned. The information is obtained to assist MO HealthNet's review of the HCAC if one is appropriate.

HCAC POST-PAYMENT REVIEW PROCESS

The review process for claims containing HCAC diagnoses that were not present at the time of admission will include a review of the claim, and any information provided during the inpatient certification review, in order to determine if the length of stay was extended by the HCAC. Medical records will be requested from the hospital as needed to complete the review. Hospitals are required to submit the medical records to the MO HealthNet Division within thirty (30) days of receipt of the request for records. Medical records will be reviewed by clinically appropriate medical professionals within the MO HealthNet Division or its contracted medical consultants to assess the quality of medical care provided and the circumstances surrounding that care.

Any potential MO HealthNet payment recoupments will be calculated by the MO HealthNet Division based on the information provided in the medical records for each HCAC reported. Recoupments will be calculated as days designated for the care associated to the HCAC. The calculation of the recoupment will be reviewed by the MO HealthNet Division Medical Director and the MO HealthNet Division Director after consideration of the review findings provided by the clinical staff completing the review. Providers have the right to appeal any adverse decision by the MO HealthNet Division regarding the recoupment of claims payment to the Administrative Hearing Commission pursuant to the provisions of 208.156, RSMo. Such payment limitation shall only apply to the hospital where the HCAC occurred and shall not apply to care provided by other hospitals should the patient subsequently be transferred or admitted to another hospital for needed care.

MEDICAL RECORD DOCUMENTATION

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment and reporting of diagnoses. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. The context of the official coding guidelines, the term “provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

Condition	HCAC Codes (ICD-9-CM Code)	Co-Requirement or Exclusion
Foreign Object Retained after Surgery	998.4 998.7	
Air Embolism	999.1	
Blood Incompatibility	999.60 999.61 999.62 999.63 999.69	
Pressure Ulcer Stages III & IV	707.23 707.24	
Falls and Trauma Fracture Dislocation Intracranial Injury Crushing injury Burn Electric Shock	800 – 829 830 – 839 850 – 854 925 – 929 940 – 949 991 – 994	
Catheter-Associated Urinary Tract Infection	996.64 The following will be considered HCAC if 996.64 is also present on the claim: 112.2 590.10 590.11 590.2 590.3 590.80 590.81 595.0 597.0 599.0	
Vascular Catheter-Associated Infection	999.31	
Manifestations of Poor Glycemic Control	250.10 – 250.13 250.20 – 250.23 251.0 249.10 – 249.11	

	249.20 – 249.21	
Surgical Site Infection, Mediastinitis, following coronary artery bypass graft (CABG)	519.2	And one of the following procedure codes: 36.10 – 36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 998.59	And one of the following procedure codes: 81.01 – 81.08 81.23 – 81.24 81.31 – 81.38 81.83 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	278.01 And one of the following diagnosis codes: 539.01 593.81 998.59	And one of the following procedure codes: 44.38 44.39 44.95
Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) Following Certain Orthopedic Procedures except for those in pediatric and obstetric patients	415.11 415.13 415.19 453.40 – 453.42	Add one of the following procedure codes: 00.85 – 00.87 81.51 – 81.52 81.54

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896