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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DATE: April 13, 2012

TO: AHCCCS Hospital Providers

FROM: Marc Leib, MD

SUBJECT: Withholding of Payments for Provider Preventable Conditions, Including Health Care Acquired Conditions and Other Provider Preventable Conditions

Section 2702 of the Affordable Care Act (ACA) prohibits Medicaid programs from reimbursing certain providers for services resulting from a “provider preventable condition” (PPC). PPCs are comprised of two categories: 1) health care acquired conditions (HCACs), and 2) other provider preventable conditions (OPPCs). Beginning July 1, 2012, AHCCCS will implement policies that conform to the federal requirements regarding HCACs and OPPCs.

HCAC

For Medicaid, HCACs are defined as conditions identified by Medicare as Hospital Acquired Conditions (HACs) occurring in the inpatient hospital setting which includes any of the following:

- Retained foreign object following surgical procedures;
- Air embolism;
- Blood incompatibility;
- Stage III and IV pressure ulcers;
- Injuries resulting from falls and trauma;
- Catheter associated urinary tract infections;
- Vascular catheter associated infections;
- Manifestations of poor glycemic control;
- Mediastinitis following coronary artery bypass graft (CABG) procedures;
- Surgical site infections following orthopedic surgery procedures involving spinal column fusion or re-fusion, arthrodeses of the shoulder or elbow, or other procedures on the shoulder or elbow;
- Surgical site infections following bariatric surgery procedures;
- Deep vein thrombosis or pulmonary embolism following total hip or knee procedures, except in pediatric or obstetrical patients.

Inpatient hospitals will not be paid any incremental or additional fees for treating an HCAC that is not present on admission to the facility, regardless of the cause of the HCAC. No reduction in payments will be assessed if the HCAC is present on admission or if the identification of the HCAC would not otherwise result in additional payments to the provider. The amount not paid to the facility is limited to the additional payments that would otherwise be paid for the treatment of and related to the HCAC.

Examples of HCACs

Example 1: Assume a patient is admitted for a procedure that would typically require only a two-day hospital stay, but during that time develops a vascular catheter associated infection and sepsis that results in an additional three-day stay in the ICU for IV antibiotics and other necessary therapies. The additional days would not be covered by AHCCCS and the additional services would not be reimbursable. The additional services cannot be used to determine whether the stay qualifies as an outlier. In addition, if the hospital stay does qualify as an outlier, even without considering the additional services, those additional services are not considered when calculating the outlier payment.

Example 2: Assume a patient is admitted for an open heart procedure. Post-operatively the patient develops a mild urinary tract infection that is successfully treated over 48-hours with IV antibiotics and then converted to oral antibiotics. Assume further that this occurred early in the post-operative period and did not delay the patient's transfer from the ICU to the regular post-operative unit and then discharge home. In this case, since no additional charges are incurred, there is no reduction in payment to the hospital for the HCAC. Similar to Example 1, additional services are not used to either qualify for or calculate payment for the stay under the outlier methodology.

OPPC

Unlike HCACs, OPPCs are not confined to conditions occurring in the inpatient hospital setting, but may occur in either the inpatient or outpatient setting. In this case, "outpatient" is not limited to hospital outpatient departments, but may include other outpatient settings, such as a clinic, Ambulatory Surgical Center (ASC), Federally Qualified Health Center, or physician's office.

State Medicaid programs have significant flexibility to define conditions they consider to be OPPCs, but at a minimum must identify any of the following three occurrences as an OPPC:

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

At this time AHCCCS will adopt the minimum list of procedures above as OPPCs for purposes of implementing Section 2702 of the ACA. When an OPPC occurs in either the inpatient or outpatient setting, payments for the services resulting in the OPPC will not be made to either the facility in which the OPPC occurred or to the professionals involved in performing the procedure that resulted in the OPPC.

Reporting

Under the federal rule implementing Section 2702, providers must affirmatively report the occurrence of any PPC in a Medicaid member, regardless of whether the provider has submitted a claim for payment for the services that resulted in the PPC. Providers should report these occurrences through the use of the appropriate codes on the UB04 claim form in the case of a hospital or the CMS 1500 claim form for professionals.

For further information or questions refer to

<http://www.azahcccs.gov/commercial/ProviderBilling/ProviderBilling.aspx>