

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL SERVICES

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June 14, 2012

Dear Provider:

South Dakota Medicaid will implement Section 2702 of the federal legislation known as the Patient Protection and Affordable Care Act (ACA) which requires Medicaid providers to report certain Health Care-Acquired Conditions (HCAC) and State Medicaid programs to deny payments for costs associated with their treatment effective July 1, 2012.

The ACA requires that at a minimum, Medicaid programs implement reporting and non-payment for certain HCAC in the inpatient hospital setting and in all care settings for the “three wrongs” that include surgery or a major procedure on the wrong patient, wrong site, or wrong surgery. South Dakota Medicaid will implement only the minimum required.

Medicare has implemented a similar provision which should make this process familiar to providers that currently bill Medicare. Medicare currently allows the exemption of certain inpatient hospital settings from reporting; however the Medicaid federal regulations do not exempt any Medicaid inpatient services from the reporting requirements.

The final rule established “Provider-Preventable Conditions (PPC)” which is defined as two distinct categories, Health Care-Acquired Conditions (HCAC) and Other Provider- Preventable Conditions (OPPC).

Health Care Acquired Conditions:

- Apply to Medicaid inpatient hospital settings, including observation; and
- Are defined as the full list of Medicare’s HCAC, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients, as the minimum requirements for States’ PPC non-payment programs.

Other Provider-Preventable Conditions include:

- Any Medicaid care settings where these events may occur;
- Surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery

Effective July 1, 2012, providers are required to identify provider preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. Providers will report this information through the claims submission process. Federal regulations require providers to report these provider preventable conditions through the claims submission process even if no payment is expected.

Claims submitted to South Dakota Medicaid that identify provider preventable conditions will pend for manual pre-payment review. Claims will be reviewed and adjusted accordingly so that the charges associated with the provider preventable condition are not reimbursed to the provider.

Attachment 1 and Attachment 2 provide additional guidance for providers related to these new requirements. Attachment 1 outlines the list of reportable conditions applicable to inpatient hospital settings and includes specific information to correctly complete the UB04 claim form. This information is also located in the Institutional Billing Manual under the non-covered section as well as the locator 67 instructions.

Attachment 2 includes information and instructions regarding billing and reporting in any care setting where surgery is performed on the wrong patient, wrong site, or a wrong surgery and includes specific information to correctly complete the CMS 1500 or UB04. This information is also located in the Professional and Institutional Billing Manuals under the non-covered section and the instructions for block 24d in the Professional manual and locator 44 in the Institutional manual. These manuals are available online at: <http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx>

Please contact Jodi Litz at MEDICAL@state.sd.us or the number above if you have any additional questions.

Sincerely,

Division of Medical Services

Attachment 1: Medicaid Inpatient Hospital Settings

Providers are required to identify Provider Preventable Conditions (PPC) that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. For reporting purposes, claims must be submitted to Medicaid to indicate these PPCs even if no payment is expected.

The list below applies to Medicaid inpatient hospital settings and is defined as the full list of Medicare's Health Care-Acquired Conditions as the minimum requirements for States' PPC non-payment programs.

- 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.
 - Manifestations of Poor Glycemic Control
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
 - Catheter-Associated Urinary Tract Infection (UTI)
 - Vascular Catheter-Associated Infection
 - 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) except when in pediatric and obstetric patients
 - Total Knee Replacement.
 - Hip Replacement.

Billing/Reporting Instructions:

When one of the PPC above occurs in an inpatient setting, including observation, it must be indicated on the UB04 claim form with the appropriate ICD-9-CM code in box 67. Any time one of the PPC ICD-9-CM codes is entered it must be accompanied by the appropriate Present On Admission (POA) indicator in box 67. The POA indicators are listed in the table below. If a POA indicator is not entered following a PPC ICD-9-CM code the claim will deny for reason 456-ADMISSION INFORMATION IS INVALID/INCOMPLETE. When a POA indicator of N or U is entered the claim will pend for reason 946-REVIEW BY MEDICAL CONSULTANT REQUIRED for pricing to exclude the PPC.

UB04 locator 67 - Present on Admission (POA) Indicators

Y	Diagnosis was present at time of inpatient admission. Medicaid will pay the CC/MCC DRG/ or charges
N	Diagnosis was not present at time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Medicaid will pay the CC/MCC DRG/or charges

This information can also be found in the Institutional Claims Manual under the non-covered services section and locator 67 instructions. These manuals are available online at: <http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx>

Attachment 2: Any Care Setting

Other Provider Preventable Conditions (OPPC) includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. **For any providers whom this applies**, these OPPCs must be reported on the claims in any care setting in which they occur. Claims indicating one of the OPPCs will *deny for 47-PROCEDURE/NDC NOT COVERED BY MEDICAID* or pay at \$0. Because these can occur at any care setting they can be billed on either the CMS 1500 or UB04 as appropriate. Below are the procedure code modifiers to report on the claim where indicated. This should be included on the claim by the facility/provider that performed the service.

Procedure code modifiers: CMS 1500 block 24d or UB04 locator 44 These must be billed as the primary modifier on the claim.

- Bill procedure code modifier: **PB** SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG PATIENT
- Bill procedure code modifier: **PC** WRONG SURGERY OR OTHER INVASIVE PROCEDURE ON PATIENT
- Bill procedure code modifier: **PA** SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG BODY PART

ICD-9 codes: CMS 1500 block 21 or UB04 locator 67

- Bill ICD-9 code: E876.5 Performance of inappropriate operation
- Bill ICD-9 code: E876.6 Performance of operation (procedure) on patient not scheduled for surgery
- Bill ICD-9 code: E876.7 Performance of correct operation (procedure) on wrong side/body part

This information can also be found in the Institutional and Professional Claims Manual under the non-covered services section as well as instructions for block 24d in the Professional manual and locator 44 in the Institutional manual. These manuals are available online at:
<http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx>