



PREVENTABLE ADVERSE EVENTS
Report to the Texas Legislature

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Texas Health and Human Services Commission

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Executive Summary

The 2010-11 General Appropriations Act (Article IX, Section 17.78, S.B. 1, 81st Legislature, Regular Session, 2009) appropriated funds for claims system modifications to deny payments for preventable adverse events, and requires the Health and Human Services Commission (HHSC) to submit a progress report by November 1, 2010, on the implementation of new rules related to preventing payment for hospital medical errors in the Medicaid program.

Additionally, HHSC adopted rules that require hospitals to submit present on admission indicators pursuant to S.B. 203, 81st Legislature, Regular Session, 2009. HHSC will impose reimbursement denials or reductions for preventable adverse events as defined by Medicare. These rules were effective beginning September 1, 2010. System changes were made to the Medicaid claims system for claims with dates of service on or after September 1, 2010, to comply with the new requirements.

Background

S.B. 203 requires the adoption of rules regarding the denial or reduction of reimbursement under the Medicaid program for preventable adverse events, sometimes referred to as “never events,” that occur in a hospital setting. S.B. 203 also requires that HHSC impose the same reimbursement denials or reductions for preventable adverse events as the Centers for Medicare and Medicaid Services (CMS) imposes in Medicare for the same types of health care-associated adverse conditions and the same types of health care providers and facilities.

Since the enactment of S.B. 203, CMS has expanded its Medicare preventable adverse events policy, originally limited to hospital settings, to include certain outpatient services and professional services. HHSC will align Medicaid policies regarding the types of preventable adverse events with Medicare as much as possible and will add other preventable adverse events as deemed appropriate.

HHSC made rule changes to the Texas Administrative Code by adding new section 354.1070 and amending sections 354.1071 and 354.1072 in Title 1, Part 15, Chapter 354, Subchapter A, Division 6, Hospital Services. The changes included providing definitions for present on admission (POA) indicator, preventable adverse event, and potentially preventable readmission. Amendments were also made to require the POA indicators for all inpatient claims, require erroneous surgeries, procedures and treatments be submitted with the appropriate modifier as defined by HHSC, and enable HHSC to impose reimbursement denials or reductions for preventable adverse events.

Medicare Hospital Acquired Conditions and Never Events

On July 31, 2008, CMS issued guidance to State Medicaid Directors related to coordination of State Medicaid payment policies with policies recently adopted by the Medicare program regarding billing for selected hospital-acquired conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of Serious Reportable Events, commonly referred to as “never events.” NQF defines “never events” as errors in medical care that are of concern to both

the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.

In developing the HAC payment policy, Medicare selected certain conditions according to the criteria contained in section 5001(c) of the Deficit Reduction Act (DRA) of 2005. This provision amended Medicare hospital payment methodology and required the Secretary to select at least two HACs that meet all of the following criteria:

- High cost, high volume, or both.
- Identified through International Classification Diagnosis-9 coding as a complicating condition or major complicating condition that, when present as a secondary diagnosis at discharge, results in payment at a higher Medicare Severity-Diagnosis Related Group (MS-DRG).
- Reasonably preventable through application of evidence-based guidelines.

CMS required hospitals to begin reporting on claims for discharges, beginning October 1, 2007, whether or not the selected conditions were present on admission. Payment reductions under Medicare began on October 1, 2008. When acquired in a hospital, these selected conditions will no longer lead to a higher Medicare payment. CMS exercised its authority under section 5001(c) of the DRA by announcing that Medicare will no longer pay the extra cost of treating the following categories of conditions that occur while the patient is in the hospital:

- Pressure ulcer stages III and IV.
- Falls and trauma.
- Surgical site infection after bariatric surgery for obesity, certain orthopedic procedures, and bypass surgery (mediastinitis).
- Vascular-catheter associated infection.
- Catheter-associated urinary tract infection.
- Administration of incompatible blood.
- Air embolism.
- Foreign object unintentionally retained after surgery.
- Deep vein thromboses and pulmonary emboli associated with knee and hip replacements.
- Certain manifestations of poor glycemic control.

In addition to the HACs listed above, Medicare announced it was initiating the National Coverage Determination process to review Medicare coverage of three “never events”: surgery on wrong body part; surgery on wrong patient; and performing the wrong surgery on a patient. Medicare will no longer pay the higher MS-DRGs arising from these selected conditions, if they arose in the course of an admission.

Present on Admission Claims Submission Requirements for Medicaid

Effective September 1, 2010, the POA indicator is required on all claims for Medicaid hospital providers that are reimbursed using the MS-DRG (Medicare Severity Diagnosis Related Groups) prospective payment system methodology. POA is defined as present at the time the order for

inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

The POA Values Are:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission.	Payment will be made by Medicaid when a HAC is present.
N	Diagnosis was not present at the time of admission.	Either no payment or a possible reduction in payment will be made by Medicaid when a HAC is present.
U	Documentation was insufficient.	Either no payment or a possible reduction in payment will be made by Medicaid when a HAC is present.
W	Clinically undetermined.	Payment will be made by Medicaid when a HAC is present.
1	Exempt from POA reporting.	Exempt from POA reporting.

The DRG may be recalculated depending on the POA indicator value, which will result in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a DRG recalculation, the lesser of the number of days will be reimbursed.

Medicaid present on admission reporting is required for all inpatient hospital claims except for the following facilities that Medicare exempts or that are paid for using the Tax Equity Fiscal Responsibility Act (TEFRA) methodology. These facilities include:

- Critical access hospitals (CAH).
- Cancer hospitals.
- Children’s inpatient facilities.
- State-owned teaching facilities.
- Rural health clinics (RHC).
- Federally qualified health centers (FQHC).
- Religious non-medical healthcare institutions.
- Inpatient psychiatric hospitals and institutes for mental disease (IMD).
- Inpatient rehabilitation facilities (IRF).
- Military hospitals.

Medicaid Claims Processing Impact in September 2010

As of September 30, 2010, a total of 10,288 claims have processed with the POA indicator. Of these claims, nine were denied for incorrect POA submission and zero claims have had their payments downgraded or denied for POA.