WSR 22-23-084
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 14, 2022, 10:24 a.m.]

Title of Rule and Other Identifying Information: WAC 182-501-0215 Wraparound with intensive services (WISe) and 182-502-0022 Provider preventable conditions (PPCs)—Payment policy.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct a website address.

Reasons Supporting Proposal: The agency is amending WAC 182-501-0215 to correct the wraparound with intensive services (WISe) website address. The correct address is https://www.hca.wa.gov/billers-providers-partners/program-information-providers/wraparound-intensive-services-wise. The agency is amending WAC 182-502-0022 to correct the agency's forms and publications website address. The correct address is https://www.hca.wa.gov/billers-providers-partners/forms-and-publications.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.160.

Statute Being Implemented: RCW 41.05.021, 41.06.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The expedited rule-making process is appropriate because the proposed rules only correct typographical errors.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 14, 2022
Wendy Barcus
Rules Coordinator

OTS-4172.1

AMENDATORY SECTION (Amending WSR 22-08-013, filed 3/24/22, effective 4/24/22)

WAC 182-501-0215 Wraparound with intensive services (WISe). (1) Wraparound with intensive services (WISe) is a service delivery model that provides comprehensive behavioral health covered services and support to:

(a) Clients age 20 or younger with complex behavioral health needs who are eligible for coverage under WAC 182-505-0210; and

(b) Their families.

(2) The authority, the managed care organizations, and the WISe provider agencies must use, continue to use, and substantially comply with the WISe quality plan (WISe QP) for the delivery of WISe. The purpose of the WISe QP is to:

(a) Provide a framework for quality management goals, objectives, processes, tools, and resources to measure the implementation and success of the WISe service delivery model; and

(b) Guide production, dissemination, and use of measures used to inform and improve WISe service delivery.

(3) The WISe QP, as may be amended from time to time, is incorporated by reference and is available online at ((~~https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/wraparound-intensive-services-wise~~)) www.hca.wa.gov/billers-providers-partners/program-information-providers/wraparound-intensive-services-wise.

[Statutory Authority: RCW 41.05.021, 41.05.160, and Thurston County Superior Court in A.G.C. v. Washington State Health Care Authority, no. 21-2-00479-34. WSR 22-08-013, § 182-501-0215, filed 3/24/22, effective 4/24/22. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-15-026, § 182-501-0215, filed 7/7/20, effective 8/7/20.]

OTS-4173.1

AMENDATORY SECTION (Amending WSR 19-08-037, filed 3/28/19, effective 4/28/19)

WAC 182-502-0022 Provider preventable conditions (PPCs)—Payment policy. (1) This section establishes the agency's payment policy for services provided to medicaid clients on a fee-for-service basis or to a client enrolled in a managed care organization (defined in WAC 182-538-050) by health care professionals and inpatient hospitals that result in provider preventable conditions (PPCs).

(2) The rules in this section apply to:

(a) All health care professionals who bill the agency directly; and

(b) Inpatient hospitals.

(3) Definitions. The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) **Agency** - See WAC 182-500-0010.

(b) **Health care-acquired conditions (HCAC)** - A condition occurring in any inpatient hospital setting (identified as a hospital ac-

quired condition by medicare other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at((÷)) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(c) **Other provider preventable conditions (OPPC)** - The list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 and published by the National Quality Forum.

(d) **Present on admission (POA) indicator** - A status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(e) **Provider preventable condition (PPC)** - An umbrella term for hospital and nonhospital acquired conditions identified by the agency for nonpayment to ensure the high quality of medicaid services. PPCs include two distinct categories: Health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

(4) **Health care-acquired condition (HCAC)** - The agency will deny or recover payment to health care professionals and inpatient hospitals for care related only to the treatment of the consequences of a HCAC.

(a) HCAC conditions include:

(i) Foreign object retained after surgery;

(ii) Air embolism;

(iii) Blood incompatibility;

(iv) Stage III and IV pressure ulcers;

(v) Falls and trauma:

(A) Fractures;

(B) Dislocations;

(C) Intracranial injuries;

(D) Crushing injuries;

(E) Burns;

(F) Other injuries.

(vi) Manifestations of poor glycemic control:

(A) Diabetic ketoacidosis;

(B) Nonketotic hyperosmolar coma;

(C) Hypoglycemic coma;

(D) Secondary diabetes with ketoacidosis;

(E) Secondary diabetes with hyperosmolarity.

(vii) Catheter-associated urinary tract infection (UTI);

(viii) Vascular catheter-associated infection;

(ix) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG);

(x) Surgical site infection following bariatric surgery for obesity:

(A) Laparoscopic gastric bypass;

(B) Gastroenterostomy; or

(C) Laparoscopic gastric restrictive surgery.

(xi) Surgical site infection following certain orthopedic procedures:

(A) Spine;

(B) Neck;

(C) Shoulder;

(D) Elbow.

(xii) Surgical site infection following cardiac implantable electronic device (CIED).

(xiii) Deep vein thrombosis/pulmonary embolism (DVT/PE) following certain orthopedic procedures:

(A) Total knee replacement; or

(B) Hip replacement.

(xiv) Latrogenic pneumothorax with venous catheterization.

(b) Hospitals must include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator is to be used according to the official coding guidelines for coding and reporting and the CMS guidelines. The POA indicator may prompt a review, by the agency or the agency's designee, of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines. The agency will identify professional claims using the information provided on the hospital claims.

(c) HCACs are based on current medicare inpatient prospective payment system rules with the inclusion of POA indicators. Health care professionals and inpatient hospitals must report HCACs on claims submitted to the agency for consideration of payment.

(5) **Other provider preventable condition (OPPC)** - The agency will deny or recoup payment to health care professionals and inpatient hospitals for care related only to the treatment of consequences of an OPPC when the condition:

(a) Could have reasonably been prevented through the application of nationally recognized evidence based guidelines;

(b) Is within the control of the hospital;

(c) Occurred during an inpatient hospital admission;

(d) Has a negative consequence for the beneficiary;

(e) Is auditable; and

(f) Is included on the list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 effective on the date the incident occurred. The list of serious reportable events in health care, as of the publishing of this rule, includes:

(i) Surgical or invasive procedure events:

(A) Surgical or other invasive procedure performed on the wrong site;

(B) Surgical or other invasive procedure performed on the wrong patient;

(C) Wrong surgical or other invasive procedure performed on a patient;

(D) Unintended retention of a foreign object in a patient after surgery or other invasive procedure;

(E) Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

(ii) Product or device events:

(A) Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the hospital;

(B) Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;

(C) Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a hospital.

(iii) Patient protection events:

(A) Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person;

(B) Patient death or serious injury associated with patient elopement;

(C) Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a hospital.

(iv) Care management events:

(A) Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);

(B) Patient death or serious injury associated with unsafe administration of blood products;

(C) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a hospital;

(D) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

(E) Patient death or serious injury associated with a fall while being cared for in a hospital;

(F) Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a hospital (not present on admission);

(G) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;

(H) Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results.

(v) Environmental events:

(A) Patient death or serious injury associated with an electric shock in the course of a patient care process in a hospital;

(B) Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances;

(C) Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a hospital;

(D) Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a hospital.

(vi) Radiologic events: Death or serious injury of a patient associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area.

(vii) Potential criminal event:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(B) Abduction of a patient of any age;

(C) Sexual abuse/assault on a patient within or on the grounds of a health care setting;

(D) Death or serious injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting.

(6) Reporting PPCs.

(a) The agency requires inpatient hospitals to report PPCs (as appropriate according to (d) and (e) of this subsection) to the agency by using designated present on admission (POA) indicator codes and appropriate HCPCs modifiers that are associated:

(i) With claims for medical assistance payment; or

(ii) With courses of treatment furnished to clients for which medical assistance payment would otherwise be available.

(b) Health care professionals and inpatient hospitals must report PPCs associated with medicaid clients to the agency even if the provider does not intend to bill the agency.

(c) Use of the appropriate POA indicator codes informs the agency of the following:

(i) A condition was present at the time of inpatient hospital admission or at the time the client was first seen by the health care professional or hospital; or

(ii) A condition occurred during admission or encounter with a health care professional either inpatient or outpatient.

(d) Hospitals must notify the agency of an OPPC associated with an established medicaid client within ((~~forty-five~~)) 45 calendar days of the confirmed OPPC in accordance with RCW 70.56.020. If the client's medicaid eligibility status is not known or established at the time the OPPC is confirmed, the agency allows hospitals ((~~thirty~~)) 30 days to notify the agency once the client's eligibility is established or known.

(i) Notification must be in writing, addressed to the agency's office of program integrity, and include the OPPC, date of service, client identifier, and the claim number if the facility submits a claim to the agency.

(ii) Hospitals must complete the appropriate portion of the HCA 12-200 form to notify the agency of the OPPC. Agency forms are available for download at((÷)) https://www.hca.wa.gov/billers-providers-partners/forms-and-publications.

(e) Health care professionals or designees responsible for or may have been associated with the occurrence of a PPC involving a medicaid client must notify the agency within ((~~forty-five~~)) 45 calendar days of the confirmed PPC in accordance with chapter 70.56 RCW. Notifications must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, and client identifier. Providers must complete the appropriate portion of the HCA 12-200 form to notify the agency of the PPC. Agency forms are available for download at((~~: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx~~)) www.hca.wa.gov/billers-providers-partners/forms-and-publications.

(f) Failure to report, code, bill or claim PPCs according to the requirements in this section will result in loss or denial of payments.

(7) Identifying PPCs. The agency may identify PPCs as follows:

(a) Through the department of health (DOH); or

(b) Through the agency's program integrity efforts, including:

(i) The agency's claims payment system;

(ii) Retrospective hospital utilization review process (see WAC 182-550-1700);

(iii) The agency's provider payment review process (see WAC 182-502-0230);

(iv) The agency's provider audit process (see chapter 182-502A WAC); and

(v) A provider or client complaint.

(8) Payment adjustment for PPCs. The agency or its designee conducts a review of the PPC prior to reducing or denying payment.

(a) The agency does not reduce, recoup, or deny payment to a provider for a PPC when the condition:

(i) Existed prior to the initiation of treatment for that client by that provider. Documentation must be kept in the client's clinical record to clearly support that the PPC existed prior to initiation of treatment; or

(ii) Is directly attributable to a comorbid condition(s).

(b) The agency reduces payment to a provider when the following applies:

(i) The identified PPC would otherwise result in an increase in payment; and

(ii) The portion of the professional services payment directly related to the PPC, or treatment of the PPC, can be reasonably isolated for nonpayment.

(c) The agency does not make additional payments for services on claims for covered health care services that are attributable to HCACs and/or are coded with POA indicator codes "N" or "U."

(d) Medicare crossover claims. The agency applies the following rules for these claims:

(i) If medicare denies payment for a claim at a higher rate for the increased costs of care under its PPC policies:

(A) The agency limits payment to the maximum allowed by medicare;

(B) The agency does not pay for care considered nonallowable by medicare; and

(C) The client cannot be held liable for payment.

(ii) If medicare denies payment for a claim under its national coverage determination agency from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(A) The agency does not pay the claim, any medicare deductible or any coinsurance related to the inpatient hospital and health care professional services; and

(B) The client cannot be held liable for payment.

(9) The agency will calculate its reduction, denial or recoupment of payment based on the facts of each OPPC or HCAC. Any overpayment applies only to the health care professional or hospital where the OPPC or HCAC occurred and does not apply to care provided by other health care professionals and inpatient hospitals, should the client subsequently be transferred or admitted to another hospital for needed care.

(10) Medicaid clients are not liable for payment of an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the agency, and must not be billed for any item or service related to a PPC.

(11) Provider dispute process for PPCs.

(a) A health care professional or inpatient hospital may dispute the agency's reduction, denial or recoupment of payment related to a PPC as described in chapter 182-502A WAC.

(b) The disputing health care professional or inpatient hospital must provide the agency with the following information:

(i) The health care professional or inpatient hospital's assessment of the PPC; and

(ii) A complete copy of the client's medical record and all associated billing records, to include itemized statement or explanation of charges.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-08-037, § 182-502-0022, filed 3/28/19, effective 4/28/19. Statutory Authority: RCW 41.05.021. WSR 13-19-038, § 182-502-0022, filed 9/11/13, effective 10/12/13. Statutory Authority: 42 C.F.R. § 447.26. WSR 13-11-051, § 182-502-0022, filed 5/14/13, effective 7/1/13.]