



PROPOSED RULE MAKING

CR-102 (June 2004)

(Implements RCW 34.05.320)

Do **NOT** use for expedited rule making

Agency: Department of Social and Health Services, Health and Recovery Services Administration

- Preproposal Statement of Inquiry was filed as WSR 09-04-071; or
- Expedited Rule Making--Proposed notice was filed as WSR _____; or
- Proposal is exempt under RCW 34.05.310(4).

- Original Notice
- Supplemental Notice to WSR
- Continuance of WSR

Title of rule and other identifying information: (Describe Subject)

The department is creating WAC 388-550-1650 Serious adverse events, hospital-acquired conditions, and present on admission indicators.

Hearing location(s):

Blake Office Park East – Rose Room
4500 – 10th Ave. SE
Lacey, Washington 98503
(One block north of the intersection of Pacific Ave. SE and Alhadeff Lane. A map or directions are available at <http://www.dshs.wa.gov/msa/rpau/docket.html> or by calling 360-664-6094)

Date: **September 22, 2009** Time: **10:00 a.m.**

Submit written comments to:

Name: DSHS Rules Coordinator
Address: PO Box 45850, Olympia WA, 98504-5850
Delivery: 4500 – 10th Ave. SE, Lacey, Washington 98503
E-mail: DSHSRPAURulesCoordinator@dshs.wa.gov
Fax: (360) 664-6185

by
5 p.m. on September 22, 2009

Assistance for persons with disabilities: Contact Jennisha Johnson, DSHS Rules Consultant by September 8, 2009
TTY (360) 664-6178 or (360) 664-6094 or
by e-mail at johnsjl4@dshs.wa.gov

Date of intended adoption: Not sooner than September 23, 2009. (Note: This is **NOT** the **effective** date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The rule implements new policy pertaining to payment or denial of payment for hospital claims that involve serious adverse events, hospital-acquired conditions, and/or present on admission indicators, and tells hospital providers the conditions under which the department will not pay for, or only make partial payments for, claims involving serious adverse events, hospital-acquired conditions, and/or present on admission indicators.

Reasons supporting proposal:

The new section is consistent with the guidelines set by the Centers for Medicare & Medicaid Services (CMS) for Medicare payment reforms that support adjusting payments to hospitals based on quality and efficiency of care. The rule provides a strong incentive for hospitals to make a correct diagnosis of symptoms upon admission (or as soon thereafter), exercise precautions to avoid unnecessary surgical procedures, reduce hospital-acquired conditions, and improve the quality of care that medical assistance clients receive in hospitals.

Statutory authority for adoption:
RCW 74.08.090 and 74.09.500

Statute being implemented:
RCW 74.08.090 and 74.09.500

Is rule necessary because of a:

- Federal Law? Yes No
- Federal Court Decision? Yes No
- State Court Decision? Yes No

If yes, CITATION:

DATE

August 10, 2009

NAME (type or print)

Don Goldsby

SIGNATURE

TITLE

Manager, Rules and Policies Assistance Unit

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 18, 2009

TIME: 9:00 AM

WSR 09-17-103

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

None

Name of proponent: (person or organization) Department of Social and Health Services

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Kathy Sayre	PO Box 45505, Olympia WA 98504-5504	(360) 725-1342
Implementation.... Carolyn Adams	PO Box 45510, Olympia WA 98504-5510	(360) 725-1854
Enforcement..... Carolyn Adams	PO Box 45510, Olympia WA 98504-5510	(360) 725-1854

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No. Explain why no statement was prepared.

These rules do not impact small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name: Carolyn Adams

Address: Health and Recovery Services Administration

PO Box 45510

Olympia WA 98504-5510

phone (360) 725-1854

fax (360) 753-9152

e-mail adamscr@dshs.wa.gov

No: Please explain:

NEW SECTION

WAC 388-550-1650 Serious adverse events, hospital-acquired conditions, and present on admission indicators. (1) The rules in this section apply to:

(a) Inpatient hospital claims with dates of admission on and after November 1, 2009;

(b) Payment or denial of payment for any inpatient hospital claims identified in (a) of this subsection, including medicaid supplemental or enhanced payments and medicaid disproportionate share hospital (DSH) payments or denial of payment;

(c) Serious adverse events, hospital-acquired conditions (HACs), and present on admission (POA) indicators (defined in subsection (2) of this section);

(d) Hospital requirements to report serious adverse events and HACs to the department (see subsection (4)(a) of this section);

(e) Hospital requests for retrospective utilization reviews and the related requirements to provide root cause analysis of events to the department (see subsection (4)(d) through (f) of this section); and

(f) Hospital requirements to use POA indicator codes on claims (see subsection (4)(g) of this section).

(2) The following definitions apply to this section:

(a) **"Serious adverse events"** (also known as "adverse health events," "adverse events," or "never events") are the events that must be reported to the department of health (DOH) under WAC 246-320-146. These events are clearly identifiable, preventable, and serious in their consequences for patients, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization. Some "hospital-acquired conditions (HACs)" can become a serious adverse event if the:

(i) Patient dies or is seriously disabled; or

(ii) Level of severity is great, such as the patient develops level 3 or 4 pressure ulcers.

(b) **"Hospital-acquired condition (HAC)"** is a condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission. HACs are identified by the U. S. Secretary of Health and Human Services per Section 5001(c) of the Deficit Reduction Act (DRA) of 2005 (42 U.S.C. § 1395ww(d)(4)(D)) and the medicare hospital-acquired condition policy (http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage) HACs are conditions that:

(i) Are high cost or high volume or both;

(ii) Result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis; and

(iii) Could reasonably have been prevented through the application of evidence-based guidelines.

(c) **"Serious disability"** means a physical or mental impairment

that substantially limits the major life activities of a patient.

(d) **"Present on admission (POA) indicator"** is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)

(e) **"Root cause analysis"** is a class of problem-solving methods aimed at identifying the root causes of events instead of addressing the immediate, obvious symptoms.

(3) **Medicare crossover inpatient hospital claims.** The department applies the following rules for these claims:

(a) If medicare denies payment for a claim at a higher rate for the increased costs of care under its HAC and/or POA indicator policies:

(i) The department limits payment to the maximum allowed by medicare;

(ii) The department does not pay for care considered nonallowable by medicare; and

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

(b) If medicare denies payment for a claim under its National Coverage Determination authority from Section 1862 (a) (1) (A) of the Social Security Act (42 U.S.C. 1395) for a serious adverse health event:

(i) The department does not pay the claim, any medicare deductible, and/or any co-insurance related to the inpatient hospital services; and

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

(4) **Inpatient hospital claims (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section).** The department applies the following rules for these claims:

(a) When the department requests information from a hospital regarding serious adverse events that the hospital reported to DOH, the hospital must provide the information requested for any affected medical assistance client (this includes both fee-for-service clients and clients enrolled in a managed care organization (MCO) contracted with the department). If no medical assistance client was affected by a serious adverse event, the hospital must provide a written response to the department with an assurance that no medical assistance clients were affected.

(b) The department does not pay for serious adverse events reported to DOH by the hospital or identified through the department's retrospective utilization review process (see (a) of this subsection).

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

(d) A hospital may request a retrospective utilization review by the department, as described in WAC 388-550-1700 (6) (a) and (b) (iii), from the department or its designee to determine if the payment of a serious adverse event should be only partially denied.

(e) A hospital that requests a department retrospective utilization review of a serious adverse event must provide the department with the hospital's root cause analysis, as described in WAC 246-320-146(3) and (4), of the serious adverse event claim.

(f) The healthcare information that is part of the

retrospective utilization review, including the root cause analysis of the serious adverse event claim, is exempt from public disclosure under RCW 42.56.360(1)(c).

(g) All hospitals that have signed a core provider agreement with the department must provide information to the department by using POA indicator codes on each claim (refer to the table in this subsection). These POA indicator codes must designate which procedures or complications were present on admission, and which occurred during, or as a result of, hospital care. POA indicator codes are to be assigned to principal and secondary diagnosis (as defined in Section II of the Official Guidelines for Coding and Reporting), and the external cause of injury codes.

POA Indicator Codes	
Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission.

(5) The department:

(i) Does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC) that are coded with POA indicator codes "N" or "U" if the claim meets the definition of an HAC.

(ii) Denies payment for any HAC that results in death or serious disability.

(6) A hospital that disagrees with a department decision to deny payment or partial payment of a serious adverse event or hospital-acquired condition may follow the administrative appeal process in WAC 388-502-0220.