Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: January 6, 2025

The proposed policy changes are currently in effect as Emergency Rules and must be promulgated as Permanent Rules. The proposed policy was presented at the March 7, 2023, Tribal Consultation and at the May 4, 2023, Medical Advisory Committee meeting. Additionally, this proposed change will be presented at a Public Hearing scheduled for January 6, 2025, and is scheduled to be presented as permanent rules to the OHCA Board of Directors on January 15, 2025.

SUMMARY: Federal regulations at 42 CFR, Section 447.26, protect Medicaid beneficiaries by prohibiting the State from paying for services that relate to provider preventable conditions (PPCs), including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs), which are medical conditions or complications that a patient develops during a hospital stay, or ambulatory surgical encounter that was not present at admission. These revisions amend administrative rules to clarify these statutory provisions and improve reporting of PPCs.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 2702 of the Patient Protection and Affordable Care Act of 2010

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 24-10

A. Brief description of the purpose of the rule:

The proposed revisions will update non-payment policies for provider preventable conditions (PPCs), including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs), which are medical conditions or complications that a patient develops during a hospital stay, or ambulatory surgical encounter that was not present at admission. The proposed rules will clarify these statutory provisions and improve reporting of PPCs.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit SoonerCare members by improving quality of care and the SoonerCare program by ensuring payments are not made for services related to provider-preventable conditions.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will be budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The Agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have a positive effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The Agency does not anticipate any detrimental effect on the public health, safety, or environment if the proposed rule changes are not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: November 19, 2024

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-62. ~~Serious reportable events - never events~~ Provider Preventable Conditions

~~(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.~~

~~(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.~~

~~(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.~~

~~(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).~~

~~(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.~~

~~(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover~~

~~hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.~~

~~(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.~~

~~(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.~~

~~(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).~~

~~(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.~~

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) "**Health care-acquired conditions (HCAC)**" means a condition occurring in any inpatient hospital setting, (identified as a hospital acquired condition by federal regulation and 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.

(2) **"National Quality Forum (NQF)"** means the independent, nonpartisan organization tasked with devising a national strategy to set standards for quality improvement and reporting in the healthcare industry.

(3) "**Other provider preventable conditions (OPPC)**" means the list of serious reportable events in health care as identified by this Section and published by the NQF.

(4) "**Present on admission (POA) indicator"** means 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.

(5) "**Provider preventable condition (PPC)**" means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this Section.

(b) **Health care-acquired conditions (HCAC)**

(1) **Payment policy**. In accordance with 42 C.F.R § 447.26, the Oklahoma Health Care Authority (OHCA) will not reimburse health care professionals and inpatient hospitals for the increased incremental cost of inpatient care services that result when a member is harmed by one (1) of the HCACs listed below.

(A) Foreign object retained after surgery;
(B) Air embolism;
(C) Blood incompatibility;
(D) Pressure ulcer stages III & IV;
(E) Falls and trauma; including:
(i) Fracture;
(ii) Dislocation;
(iii) Intracranial injury;
(iv) Crushing injury;
(v) Burn;
(vi) Electric shock;
(F) Catheter-associated urinary tract infection;
(G) Vascular catheter-associated infection;
(H) Manifestations of poor glycemic control; including:
(i) Diabetic ketoacidosis;
(ii) Nonketotic hyperosmolar coma;
(iii) Hypoglycemic coma;
(iv) Secondary diabetes with ketoacidosis;
(v) Secondary diabetes with hyperosmolarity;
(I) Surgical site infection following:
(i) Coronary artery bypass graft-mediastinitis;
(ii) Bariatric surgery; including:
(I) Laparoscopic gastric bypass;
(II) Gastroenterostomy;
(III) Laparoscopic gastric restrictive surgery;
(iii) Orthopedic procedures; including:
(I) Spine;
(II) Neck;
(III) Shoulder;
(IV) Elbow;
(iv) Cardiac implantable electronic device (CIED)
(J) Deep vein thrombosis and pulmonary embolism following:
(i) Total knee replacement with exceptions for pediatric and/or obstetric cases; or
(ii) Hip replacement with exceptions for pediatric and/or obstetric cases.
(K) Iatrogenic pneumothorax with venous catheterization

(2) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for the increased incremental cost of inpatient care services that result when a member is harmed by the HCACs identified in (b)(1) (A)-(K), the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of HCACs.

(c) **Other provider preventable condition (OPPC)**

(1) **Payment policy.** In accordance with 42 C.F.R § 447.26, the Agency will not reimburse health care professionals and inpatient hospitals for care related to the treatment of consequences of an OPPC when the condition:

(A) Is identified in the Oklahoma Medicaid State Plan;

(B) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

(C) Is within the control of the hospital;

(D) Has a negative consequence for the member;

(E) Is auditable; and

(F) Is included on the list of serious reportable events in health care by the National Quality Forum (NQF). Providers are responsible for keeping abreast of any changes to the list of serious reportable events identified by the NQF. The list of serious reportable events in health care, as of the publishing of this rule, includes surgical or invasive procedure events:

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

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

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

(2) **Billing.** For inpatient claims, hospitals are required to bill two (2) claims when the erroneous surgery is reported, one (1) claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery. Claim lines submitted with one (1) of the applicable HCPCS modifiers will be line-item denied. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an eighteen-month (18-month) period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(4) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of OPPCs.

(d) **Reporting.** Title 42 of the Code of Federal Regulations, Sections 447, 434 and 438 require providers, in both fee-for-service and managed care delivery systems, to report all PPCs that are associated with claims for SoonerCare payment or with courses of treatment furnished to a SoonerCare member for which Medicaid payment would otherwise be available. The report shall be made to the OHCA regardless of whether the provider seeks SoonerCare reimbursement for services to treat the PPCs. The Agency report form is available for download at https://oklahoma.gov/ohca. Providers must report the following information to the OHCA within 10 days of the occurrence of the event:

(1) Member name and member ID number.

(2) A description of the event.

(3) Dates of services and occurrence of the event.

(4) Attending physician(s).
(5) Facility.

(e) **Liability.** A provider cannot shift financial liability or responsibility for the non-covered services and treatment to the member if the OHCA has determined that the service is related to a PPC.

317:30-3-63. Hospital acquired conditions [REVOKED]

~~(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:~~

~~(1) Foreign Object Retained After Surgery~~
~~(2) Air Embolism~~
~~(3) Blood Incompatibility~~
~~(4) Pressure Ulcer Stages III & IV~~
~~(5) Falls and Trauma~~
~~(A) Fracture~~
~~(B) Dislocation~~
~~(C) Intracranial Injury~~
~~(D) Crushing Injury~~
~~(E) Burn~~
~~(F) Electric Shock~~
~~(6) Catheter-Associated Urinary Tract Infection~~
~~(7) Vascular Catheter-Associated Infection~~
~~(8) 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~~
~~(9) Surgical Site Infection Following:~~
~~(A) Coronary Artery Bypass Graft- Mediastinitis~~
~~(B) Bariatric Surgery~~
~~(i) Laparoscopic Gastric Bypass~~
~~(ii) Gastroenterostomy~~
~~(iii) Laparoscopic Gastric Restrictive Surgery~~
~~(C) Orthopedic Procedures~~
~~(i) Spine~~
~~(ii) Neck~~
~~(iii) Shoulder~~
~~(iv) Elbow~~
~~(10) Deep Vein Thrombosis and Pulmonary Embolism~~
~~(A) Total Knee Replacement~~
~~(B) Hip Replacement~~

~~(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.~~

~~(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.~~