

**STATE OF RHODE ISLAND  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**PUBLIC NOTICE OF PROPOSED AMENDMENT TO MEDICAID STATE  
PLAN**

In accordance Rhode Island General Laws (RIGL) 42-35, notice is hereby given that the Executive Office of Health and Human Services propose to amend the following into the Medicaid State Plan:

**Payment Adjustment for Provider Preventable Conditions, Including Hospital  
Acquired Conditions**

The Rhode Island Executive Office of Health and Human Services (EOHHS) has submitted amendments to its State Plan sections 4.19(a), 4.19(b) and 4.19(d) that identify its compliance with 42 CFR §447 for Provider Preventable Conditions (PPCs). PPCs include Health Care-Acquired Conditions (HCACs) in inpatient hospitals and Other Provider Preventable Conditions (OPPCs) in any health care setting, including but not limited to: inpatient and outpatient hospital, ASCs, physician office and nursing facilities.

Proposed changes incorporate provisions for Other Provider Preventable Conditions (OPPCs) in the General section of the Principles of Reimbursement. There will be minimal to no annual state savings for State Fiscal Year 2012 and State Fiscal Year 2013. Proposed changes also reflect the Category II change request to the Rhode Island Global Choice Compact Waiver, with an effective date of January 11, 2013, that has been submitted to Centers for Medicare and Medicaid Services (CMS) regarding a proposed reduction in nursing facility payment rates. This was also advertised on March 29, 2012 and is being incorporated into this state plan amendment. Subject to approval of the proposed amendments by CMS, the Executive Office of Health and Human Services estimates that implementation of this rate reduction will result in savings for fiscal year 2012 of \$1.5 million and annual savings for fiscal year 2013 of \$6.0 million.

In the development of these rules, consideration was given to the following: (1) alternative approaches; and (2) overlap or duplication with other statutory and regulatory provisions. No alternative approach or duplication or overlap was identified based upon available information.

This proposed rules is accessible on the R.I. Secretary of State website (<http://www.sec.state.ri.us/ProposedRules/>) and the OHHS website ([www.ohhs.ri.gov](http://www.ohhs.ri.gov)) or available in hard copy upon request (401 462-2018 or RI Relay, dial 711). Interested persons should submit data, views or written comments by Friday, February 8, 2013 to Kimberly Merolla-Brito, Office of Policy Development, Department of Human Services, Louis Pasteur Building, Bldg. 57, Howard Avenue, Cranston, RI 02920.

In Accordance with RIGL 42-35-3, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Rhode Island

**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

**Health Care-Acquired Conditions**

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

  X   Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

\_\_\_\_\_ Additional Other Provider-Preventable Conditions identified below:

The State of Rhode Island Executive Office of Health and Human Services submitted to CMS an Implementation Advance Planning Document (IAPD) on June 1, 2012. The RI Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs) IAPD amendment 1 was approved by CMS in a letter dated August 01, 2012. The IAPD outlined RI's plan to align the RI MMIS with the federally mandated Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs) coding standards.

RI's solution methodology anticipated modifications to the Rhode Island MMIS system processing and business functions. HPES analysis of the PPCs/HACs business and technical requirements identified the following areas for specification changes:

- a) RI MMIS processing modifications to accommodate a POA Indicator assignment to principal and secondary diagnoses.
- b) RIMA will systematically handle claims processing for providers who are identified by EOHHS as being exempt from POA processing. The MMIS modifications will manage diagnosis codes that are exempt. This will be accomplished with additional editing/logic within the MMIS which will assist with the payment/non-payment of claims or portions of claims based on POA/HAC.
- c) Modifications to in-house paper Inpatient claims processing. The Viking form sets will be modified to include the Present on Admission Indicator. For Impression Technology, modifications are necessary to support capturing the POA indicator fields from the UB-04 claim form.
- d) Modifications to electronic claims (HIPAA 5010 837I (institutional) format) - the Translator will allow for a “blank” POA indicator. Currently the POA indicator is required in PES. Modifications will be made to remove this editing in PES to allow “blank” as an acceptable value.
- e) Modifications to the RI MMIS functionality to allow processing of the POA indicator information to be stored within RI MMIS, to translate to the 3M DRG Grouper Interface for necessary processing.
- f) A new edit will be created within RI MMIS to identify inpatient claims that should be denied when the POA indicator is missing or invalid on the institutional inpatient claim. This edit will be deployed in combination with the programming modifications to pass the POA indicator to the DRG grouper.
- g) Modify MSIS and DSS Profiler to include the POA indicator field for each diagnosis code. A separate POA Indicator entry field must be assigned to principal and secondary diagnoses as well as the external cause of injury codes.

The RI PPCS/HACS project team began work activities in January 2012 with the goal of project implementation to complete system modifications for all critical path items by June 29, 2012. Work of the PPCS/HACS critical path change requirements to the RI MMIS System and HP Provider Electronic Solutions (PES) software was successfully completed and implemented on June 28, 2012 (with the exception of DSS Profiler, MSIS, Editing for Never Conditions and Quarterly POA reporting).

The RIMA Production Implementation on June 29, 2012 Included:

- RI MMIS new editing/logic (Edit # 286 Missing/Invalid POA Indicators). The POA indicator and new edit for inpatient claims, will affect claims with a “From Date of Service” of 07/01/12 or greater. This will assist with the payment/non-

- payment of claims based on POA indicator code submitted with the Primary and Secondary diagnosis codes. Only Exempt providers or Exempt Diagnosis codes
- will bypass this new edit. All other diagnosis codes will require a POA indicator code in these fields.
- Coding changes to the RI MMIS interface with the 3M DRG grouper which will now pass the POA indicator(s) from the claim to the DRG grouper. The 3M DRG grouper software v29 is implemented in production and completes the calculations necessary to accommodate the reduction due to HCAC's when appropriate criteria is met.
- RI MMIS will systematically handle claims processing for providers who are identified by EOHHS as being exempt from POA processing (Exempt from the HAC payment provision). This includes Psych Facility provider types (PT 003) as well as individual provider id's that are not considered IPPS hospitals. The identified "Exempt" providers are not affected by the reduction in payment.
- RI in-house paper Inpatient claims processing, the Viking screens relative to the UB-04 claim from processing which are utilized for claims resolution are changed to include the Present on Admission Indicator.
- Impression Technology®, modifications were completed to support capturing the POA indicator fields from the UB-04 claim form.
- The PES software (version 2.07) was modified to allow for blank POA indicators, the timeline to rollout this updated version of PES is being coordinated with the 5010 final evaluation of Ecode requirement.

Summary of remaining PPCS/HACS related tasks, the schedule is to be determined:

- 1) Completion of the MSIS changes to identify the POA indicator within the MSIS reporting. As of 09/25/2012 CMS has not provided a timeline to send specifications for MSIS extract changes to support the additional field(s) for "Health-care-acquired-condition-ind".
- 2) Completion of modifications to DSS profiler.
- 3) Creation of a Quarterly POA Cost Savings Report in support of the Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs) project initiative.

EOHHS will forward an Advance Planning Document Update (APDU) to CMS by November 15, 2012 that will include a request for an extension of the timeline to complete the remaining PPCS/HACS related tasks and the additional work scope identified for Inpatient, Outpatient and Professional claim types and the Quarterly POA Cost Savings Report work initiative.

- *No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.*
- *Reductions in provider payment may be limited to the extent that the following apply: (z) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.*

*A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.*

State: Rhode Island

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.
2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure.
3. Payment for physician, dentist and other individual practitioner services may be made up to the reasonable charge under Title XVIII. The upper limits with respect to any item of medical care and services provided under the State Plan shall not exceed the amounts established as the ceilings for the prices of such item pursuant to nationally imposed economic controls or limitations on the prices of goods and services. Fee schedules are posted on the Department of Human Services web site under Provider Services [http://www.dhs.ri.gov/dhs/heacre/provsvcs/fee\\_schedule.htm](http://www.dhs.ri.gov/dhs/heacre/provsvcs/fee_schedule.htm). All governmental and private service providers are reimbursed according to the same published fee schedule. The Medical assistance Program rates were set as of July 21, 2008 and are effective for services on or after that date.
4. The following is a description of the payment structure by items of service.
  - a. Inpatient hospital services: as described in attachment 4.19A.
  - b. Outpatient hospital services: Annually, the Medical Assistance Program and Rhode Island community hospitals agree to a state-wide inflation factor that applies to all in-state hospitals, which prospectively establishes the maximum allowable increase in expenses for the hospital's coming hospital fiscal year. Within one (1) year of the close of the hospital's fiscal year, each hospital must submit settlements to the state. Based on the results of the cost finding process and in conjunction with the hospital's charge structure and revenue budget, ratios of allowable costs to hospital charges (RCCs) are established for outpatient services. Each hospital must publish a list of Hospital Board approved charges and dates of implementation at the beginning of the hospital's fiscal year that are consistent for all payers. Hospitals are allowed to update their charges annually.
    1. Outpatient laboratory and imaging services will be paid separately using the Medicare allowable rate.
    2. Physician fees will be paid separately from fee schedules posted on the Department of Human Services web site under Provider Services [http://www.dhs.ri.gov/dhs/heacre/provsvcs/fee\\_schedule.htm](http://www.dhs.ri.gov/dhs/heacre/provsvcs/fee_schedule.htm).
    3. There are two outpatient RCCs. The outpatient surgery RCC will be established as described above. The outpatient RCC for all other services, exclusive of laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery RCC.
    4. Out-of- State hospitals will be reimbursed for outpatient surgery services provided to Rhode Island Medical Assistance recipients at a rate equal to fifty-three (53%) of the out-of-state hospital's customary charge(s) for such services to Title XIX recipients in that state. The outpatient reimbursement for all other services, exclusive of

laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery rate.

5. All in-state outpatient hospital payments are subject to a year-end settlement. Hospitals are required to submit settlement documents within twelve (12) months of the close of the hospital's fiscal year. Each hospital submits a state provided settlement document to submit outpatient charges, costs, and payments from the Medicaid program. Allowed costs from the prior year are adjusted by the agreed inflation factor for the fiscal year being settled. This information is reviewed by the state, adjusted where appropriate, and the new RCC is calculated by the state provided settlement document.
6. Hospital outpatient claims and payments are processed through MMIS.
7. Only hospitals and provider based entities, in accordance with 42 CFR 413.65, are reimbursed according to the outpatient hospital reimbursement methodology.
8. Outpatient Supplemental Payment and UPL Calculation
  - a. For outpatient services provided for the period July 1, 2009 to June 30, 2010 each hospital as defined in Section 23-17-38.1(c)(1) is paid an amount determined as follows:
    - 1) Determine the sum of all Medicaid payments from Rhode Island MMIS to hospitals made for outpatient and emergency department services provided during each hospital's fiscal year ending during 2008, including settlements.;
    - 2) Multiplying the result of (1) above by a percentage consistent with Medicare cost finding principles; and
    - 3) The Outpatient UPL calculation is an estimate of Medicare outpatient cost for private hospitals. Specifically, a ratio of Medicare outpatient costs to Medicare outpatient charges is applied to Medicaid outpatient and emergency room charges to determine total Medicaid cost (the limit). Total Medicaid outpatient and emergency room payments are then subtracted to determine the UPL gap, which is the basis for the size of the outpatient supplemental payment. The UPL gap is calculated using an aggregate of the individual hospital gaps for state owned and operated, non-state owned and operated, and private hospitals. The outpatient UPL calculation is a reasonable estimate of the amount Medicare would pay for equivalent Medicaid services.

Cost information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V, Columns 9.01,9.02,9.03, Line 104 (which is equal to Line 101).

Charge information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V Columns 5.01, 5.02, 5.03, Line 104 (which is equal to Line 101).

The UPL is trended for inflation and utilization using CPI-U: Hospital and Related Service – CMS Health Care Indicators, Table

7: Percent Change in Medical Prices, and OP PPS Payment Increase and Market Basket Update

- 4) Pay each hospital on July 20, October 20, January 20, and April 20 one-quarter of the product created by multiplying the result of (1) above and (2) above.

c. Payment will be made for rural health clinic services at the reasonable cost rate per visit established by the Medicare carrier. Payment for each ambulatory service, other than rural health clinic services, will be made in accordance with the rates or charges established for those services when provided in other settings

d. Intentionally left blank.

1. Intentionally left blank.

**5. Payment Adjustment for Provider Preventable Conditions**

**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19-B of this State Plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

\_\_\_\_ Additional Other Provider-Preventable Conditions identified below:

The RI PPCS/HACS project team focused on additional work scope components related to the PPCs/HACs project initiative that were identified in August 2012. The specification changes outlined additional processing to support the identification of erroneous surgery claims for claim types of Inpatient (I), Outpatient (O) and Professional (M). New edits would be constructed to identify “never conditions” (erroneous surgery) claims and process to deny. In addition, an edit for “no-pay” bills would be added for Outpatient and Inpatient claim types. System modifications were completed and the 3 new edits were implemented on 10/31/2012.

The RIMA Production Implementation on 10/31/2012 Included:

The new edits implemented within RI MMIS 10/31/2012 will identify “never” (erroneous surgery) claims and process to deny for claim types of Outpatient (O), Inpatient (I) and Professional (M). An edit for “no-pay” bills has been added for Outpatient and Inpatient claim types. The 3 new edits are:

1. ESC 287 - Do Not Pay - Erroneous Surgery Procedure Code Modifier (this will set for claim types Outpatient and Professional, if the Procedure Modifier Code of “PA-Surgery Wrong Body Part”, “PB-Surgery Wrong Patient” or “PC-Wrong Surgery on Patient” is submitted. In this scenario the entire claim will be denied (there are no modifiers on Inpatient claims).

2. ESC 288 - Do Not Pay - Erroneous Surgery Diagnosis Code (this will set for claim types Inpatient, Outpatient and Professional if the diagnosis code(s) of “E8765-”Performance of wrong operation (procedure) on correct patient, or “E8766-Performance of operation (procedure) on patient not scheduled for surgery” or “E8767-Performance of correct operation (procedure) on wrong side/body part” is submitted). In this scenario the entire claim will be denied.

3. ESC 289 - Do Not Pay - Zero Pay Bill Type (this will set for claim types Inpatient and Outpatient if type of bill submitted is “110- Inpatient Claim, Zero Pay Bill” or “130 -Outpatient Claim, Zero Pay Bill”). In this scenario the entire claim will be denied.

- *No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.*
- *Reductions in provider payment may be limited to the extent that the following apply: (z) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.*

*A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.*

**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this State plan.

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

       Additional Other Provider-Preventable Conditions identified below:

The RI PPCS/HACS project team focused on additional work scope components related to the PPCs/HACs project initiative that were identified in August 2012. The specification changes outlined additional processing to support the identification of erroneous surgery claims for claim types of Inpatient (I), Outpatient (O) and Professional (M). New edits would be constructed to identify “never conditions” (erroneous surgery) claims and process to deny. In addition, an edit for “no-pay” bills would be added for Outpatient and Inpatient claim types. System modifications were completed and the 3 new edits were implemented on 10/31/2012.

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submitted. In this scenario the entire claim will be denied (there are no modifiers on Inpatient claims).

2. ESC 288 - Do Not Pay - Erroneous Surgery Diagnosis Code (this will set for claim types Inpatient, Outpatient and Professional if the diagnosis code(s) of “E8765-”Performance of wrong operation (procedure) on correct patient, or “E8766-Performance of operation (procedure) on patient not scheduled for surgery” or “E8767-Performance of correct operation (procedure) on wrong side/body part” is submitted). In this scenario the entire claim will be denied.

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