

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



JUL 19 2013

Ms. Nancy V. Atkins, RN, MSN, NP-BC, Commissioner
Bureau for Medical Services
WV Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3706

RE: State Plan Amendment (SPA) 12-010

Dear Ms. Atkins:

We have completed our review of State Plan Amendment 12-010. This SPA modifies Attachments 4.19-A and 4.19B of West Virginia's Title XIX State Plan. Specifically, SPA 12-010 implements regulations for provider preventable conditions and related payment adjustments for Medicaid.

We conducted our review of this amendment according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We are approving SPA 12-010, effective July 1, 2012. Enclosed are the approved HCFA-179 and the amended state plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann", is written over the typed name.

Cindy Mann
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 1 2 - 0 1 0	2. STATE: West Virginia
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One) <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447, 434, 438; 1902(a)(4), 1902(a)(6) and 1903		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 0 b. FFY 2012 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 2 to Attachment 4.19-A, Page 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable). Supplement 2 to Attachment 4.19-A, Page 2	
10. SUBJECT OF AMENDMENT: This State Plan prohibits payments to providers for costs associated with Healthcare Acquired and Provider-Preventable Conditions.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Nancy V. Atkins 8/20/12</i>		16. RETURN TO: Bureau for Medical Services 350 Capitol Street Room 251 Charleston West Virginia 25301	
13. TYPED NAME Nancy V. Atkins, RN, MSN, NP-BC			
14. TITLE: Commissioner			
15. DATE SUBMITTED: 8/20/12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED JUL 19 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2012		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Mary</i>	
21. TYPED NAME: <i>Penny Thompson</i>		22. TITLE: <i>Deputy Director, Policy + Financial Mgt.</i> CRES	
23. REMARKS:			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Supplement 2 to Attachment 4.19-A

Page 2

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

With the implementation of HIPAA 5010 system conversion, inpatient hospital claims that are reimbursed under a Prospective Payment System will have payment adjusted for Hospital-Acquired Conditions (HACs) indicated by designation in the diagnosis field with a Present on Admission (POA) Indicator value of N or U. A value of N indicates that the condition was not present at the time of inpatient admission. A value of U indicates that the documentation was insufficient to determine if the condition was present at the time of inpatient admission. When either of these condition(s) exist, the claim will be paid as though the secondary diagnosis is not present. Only diagnosis codes with a POA indicator equal to Y or W will be considered for full DRG reimbursement. A value of Y indicates the condition was present upon admission while a value of W indicates that the provider is unable to clinically determine whether the condition was present at the time of admission or not.

Critical Access Hospitals (CAHs) will have payment adjusted for HACs at final cost settlement. CAHs will be required to prepare a supplemental schedule to Cost Report Form 2552-10 to aggregate all Medicaid HAC related charges and all HAC related costs. All costs and charges related to HACs will be excluded for Medicaid settlement purposes at the time of final Medicaid settlement.

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A

- 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(s) 4.19.

For claims submitted with certain condition code(s) and/or ICD-9 diagnosis codes indicating Other Provider-Preventable Conditions, claims will be denied for payment at the time of submission for:

- 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 (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example 4.19(d) nursing facility services, 4.19(b) physician services of the plan;

TN No: 12-010
Supersedes: NEW

Approval Date: JUL 19 2013

Effective Date: 07/01/12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Supplement 2 to Attachment 4.19-B

Page 2

CITATION

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

Payment Adjustment for Other 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 ("OPPC") for non-payment under Section(s) 4.19-B.

- 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.

Payments for OPPC will be adjusted accordingly:

1. Providers are mandatorily required to report OPPCs to the Agency by using diagnosis codes in the corresponding fields provided for event codes on the claims.
2. Providers are mandatorily required to also report OPPCs using corresponding CPT/HCPCS modifiers associated with the surgical procedures on all claims.
3. Claims indicating any one of the three erroneous surgeries or procedures will be reviewed and denied if appropriate.

Provider Guidelines relating to Provider Reimbursement

1. The Agency assures the Centers for Medicare and Medicaid Services ("CMS") that non-payment for OPPCs does not prevent access to services for Medicaid beneficiaries.

TN No: 12-010 Approval Date: JUL 19 2013 Effective Date: 7/01/12
Supersedes: NEW