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

(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.

317:30-3-63. Hospital acquired conditions

(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.