

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code § 1-307.02(2006 Repl. & 2012 Supp.) and section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2008 Repl.)), hereby gives notice of the adoption, of a new chapter 92 (Medicaid Payment Adjustment for Provider Preventable Conditions) of title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). This rule establishes limitations for reimbursement by the District of Columbia Medicaid program for health care acquired conditions and never-events, collectively known as provider-preventable conditions (PPCs).

On June 6, 2011, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule for the Medicaid program implementing section 2702 of the Patient Protection and Affordable Care Act (ACA) (Pub. Law 111-148; 42 C.F.R. §§434, 438, and 447). Section 2702 of the ACA prohibits federal payments to States for Medicaid expenditures on PPCs and requires states to include, at a minimum, all of the preventable conditions prohibited under Medicare's inpatient hospital payment adjustment regulations and any subsequent updates or revisions. Medicare's inpatient hospital payment adjustment regulations were promulgated under section 1886(d)(4)(D) of the Social Security Act, 42 U.S.C. 1395ww .

The rule prohibits Medicaid payments to providers for services related to PPCs, and establishes procedures for providers to self-report PPCs through their claims systems. The term "provider-preventable condition" is defined to encompass two categories: (1) Health Care Acquired Conditions (HCACs), which pertain only to hospital providers; and (2) Other Provider-Preventable Conditions (OPPCs). HCACs apply to any inpatient hospital setting and are defined as the full list of Medicare's Hospital Acquired Conditions (HACs), with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement in pediatric and obstetric patients. OPPCs are defined as conditions that apply in any healthcare service setting, and must include the three (3) specified Medicare nonpayment National Coverage Determinations (NCD) for erroneous procedures, which are the performance of: (1) the wrong procedure; (2) the correct procedure on the wrong body part; or (3) the correct procedure on the wrong patient.

The corresponding amendment to the District of Columbia State Plan for Medical Assistance (State Plan) was approved by the Council of the District of Columbia on June 15, 2012 and approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services effective July 1, 2012.

A notice of proposed rulemaking was published in the *D.C. Register* on May 11, 2012 (58 DCR 004793). Comments were received and no substantive changes have been made. The Director

adopted these rules on December 12, 2012. These rules shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 92, MEDICAID PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS, of title 29 DCMR is added to read as follows:

**CHAPTER 92 MEDICAID PAYMENT ADJUSTMENT FOR PROVIDER
PREVENTABLE CONDITIONS**

9200 GENERAL PROVISIONS

- 9200.1 The purpose of this chapter is to establish limitations for reimbursement by the Medicaid program for provider preventable conditions. These rules shall:
- (a) Identify Provider Preventable Conditions (PPCs) which shall be included in the Department of Health Care Finance (DHCF) payment adjustment policy;
 - (b) Identify providers subject to the DHCF's PPC payment adjustment policy; and
 - (c) Establish procedures for providers to self-report the occurrence of PPCs in their claims systems.
- 9200.2 Subject to the requirements set forth in Section 2702 of the Patient Protection and Affordable Care Act of 2010 (the Act), approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119; 42 C.F.R. §§ 434, 438, and 447), the DHCF's PPCs payment adjustment policy shall include all of the PPCs included in Medicare's inpatient hospital payment adjustment regulations and any subsequent updates or revisions promulgated under section 1886(d)(4)(D) of the Social Security Act (42 U.S.C. § 1395ww).
- 9200.3 The list of PPCs which are subject to payment adjustments by the DHCF under the District of Columbia's Medicaid program shall include Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPC).
- 9200.4 DHCF's PPC payment adjustment policy shall apply to all hospital claims for dates of discharge on or after July 1, 2012.
- 9200.5 For non-hospital providers, the payment adjustment policy shall apply to all claims for services rendered on or after July 1, 2012.
- 9200.6 DHCF's PPC payment adjustment policy shall also apply to the terms of the contracts entered into by Managed Care Organizations (MCOs) and the District of Columbia. The MCO's payment policies must comply with the DHCF's PPC payment adjustment policy. MCOs must ensure that their payment policies

prohibit reimbursement to its providers for any amount expended when providing medical assistance for PPCs.

9201 HEALTH CARE ACQUIRED CONDITIONS

- 9201.1 HCACs subject to payment adjustments under the District of Columbia's Medicaid program shall include those preventable medical conditions that were not present upon admission to an inpatient hospital setting, but were acquired after an inpatient admission occurs.
- 9201.2 HCACs shall consist of diagnoses identified by a secondary diagnostic code.
- 9201.3 DHCF shall adjust provider payments for the portion of the claims directly related to treatment for, and related to, the following HCACs:
- (a) Foreign object retained after surgery;
 - (b) Air embolism;
 - (c) Blood incompatibility;
 - (d) Catheter-associated urinary tract infection;
 - (e) Pressure Ulcer Stages III or IV;
 - (f) Vascular catheter-associated infection;
 - (g) Mediastinitis after coronary artery bypass graft;
 - (h) Falls and trauma resulting in fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes;
 - (i) Manifestations of poor glycemic control;
 - (j) Surgical site infection following spine, neck, shoulder, or elbow orthopedic procedures;
 - (k) Surgical site infection following bariatric surgery for obesity; and
 - (l) Deep vein thrombosis and pulmonary embolism following a total knee or hip replacement, except for pediatric (individuals under the age of twenty-one (21)) and obstetric populations.

- 9201.4 The following provider types shall be denied reimbursement for the portion of a claim attributed to HCACs:
- (a) Hospitals paid on a diagnosis-related group (DRG) basis; and
 - (b) Hospitals paid on a non-DRG basis.
- 9201.5 For all claims submitted on or after July 1, 2012, each provider shall collect and record information related to HCACs in the present on admission (POA) indicator field and on the secondary diagnosis indicator field on all applicable claims, regardless of whether the claims are submitted in a hardcopy or electronic format.
- 9201.6 Additional information, including medical records, may be requested by DHCF regarding claims for payment made on or after July 1, 2012. Providers must collect and maintain information regarding the diagnosis underlying each claim made on or after July 1, 2012, including whether the diagnosis was POA, or if the provider was unable to make such a determination due to clinical reasons or insufficient documentation.
- 9201.7 The POA and secondary diagnosis indicator requirement shall be implemented pursuant to additional guidance issued by the DHCF.
- 9201.8 A provider that fails to collect and record information in the POA indicator field or secondary diagnosis indicator field, in accordance with this section, shall be denied payment for the associated claim.
- 9202 OTHER PROVIDER PREVENTABLE CONDITIONS**
- 9202.1 Other Provider Preventable Conditions (OPPCs) shall include erroneous medical procedures as identified by Medicare under three (3) national coverage determinations (NCDs) that deny coverage when a practitioner performs the wrong procedure in any health care setting including outpatient or inpatient hospitals, ambulatory surgical centers, and practitioner settings.
- 9202.2 DHCF shall deny payment for claims associated with the following OPPCs:
- (a) Wrong surgical procedure;
 - (b) Correct procedure performed on the wrong patient; and
 - (c) Correct procedure performed on the wrong body part.
- 9202.3 The following provider types shall be denied compensation for claims associated with OPPCs:
- (a) Hospitals paid on a diagnosis-related group (DRG) basis;

- (b) Hospitals paid on a non-DRG basis; and
- (c) Other providers, regardless of whether they are paid on a fee-for-service or capitated basis.

9202.4 For all claims submitted on or after July 1, 2012, providers shall report OPPCs by using modifiers and E-codes on paper and electronic claim forms that refer to the prohibited procedures described in § 9202.2.

9202.5 The OPPC modifier and E-code requirement shall be implemented pursuant to additional guidance issued by DHCF.

9202.6 DHCF or its agent may request additional information, including medical records for admissions and/or outpatient procedures, in order to verify the occurrence or absence of an OPPC. Providers must collect and maintain information regarding the OPPC associated with each claim submitted on or after July 1, 2012, including reference to the associated prohibited procedure described in § 9202.2.

9203 CLAIMS RECOUPMENT OR RECONCILIATION

9203.1 For those beneficiaries dually-eligible for Medicare and Medicaid, the District's Medicaid PPC payment adjustment policy shall also apply to those claims denied under Medicare's preventable conditions policy.

9203.2 A Medicaid provider shall be subject to reimbursement recoupment or reconciliation based on the Medicaid Provider Preventable Conditions Payment Adjustment Policy. A determination of overpayments and/or underpayments shall be based on one (1) or more of the following factors:

- (a) Whether the procedure or diagnosis underlying the claim is a PPC;
- (b) Whether the condition results in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis;
- (c) Whether the claim resulting from the service was priced correctly;
- (d) Whether the provider properly coded the claim by using the present on admission (POA) indicator field; and
- (e) Whether the claim duplicates a previously paid claim.

9299 DEFINITIONS

9299.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

Beneficiary – An individual who is eligible for medical assistance (Medicaid and CHIP) under Titles XIX (42 U.S.C. 1396a) or XXI (42 U.S.C. § 1397aa) of the Social Security Act.

Health-Care Acquired Conditions – The full range of Medicare hospital-acquired conditions (HACs), with the exception of deep vein thrombosis/pulmonary embolism following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions – Conditions that apply in any health care service setting when a practitioner performs the wrong procedure, the correct procedure on the wrong patient, or the correct procedure on the wrong body part.

Present on admission – A condition that is present at the time an inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, during observation, or outpatient surgery, are considered to be present on admission.

Provider-preventable conditions- (1) Health Care Acquired Conditions or (2) Other Provider- Preventable Conditions.

Managed Care – The program authorized under section 1915(b) of the Social Security Act (42 U.S.C. § 1396 n) in which Medicaid beneficiaries are enrolled into managed care plans to receive services.