

State/Territory: California

Payment Adjustment for Provider-Preventable Conditions

Medi-Cal meets the requirements of 42 CFR Part 447, Subpart A, and Social Security Act 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.

- 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.

- 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.

TN No. 12-004
Supersedes
TN No. None

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Medi-Cal does not reimburse providers for provider-preventable conditions (PPC).
Provider-preventable conditions mean the following:

- Health Care-acquired Condition (HCAC), as identified in Title 42 of the Code of Federal Regulations, Part 447.26(b).
- Other Provider-Preventable Condition (OPPC), as identified in Title 42 CFR Part 447.26(b).

Providers shall report any PPCs that did not exist prior to initiation of treatment for that patient by the provider(s) that are associated with the course of treatment furnished to Medi-Cal patients for which Medi-Cal payment would otherwise be available. The reporting will be directed to the State. In addition to providers identifying PPCs using the Medi-Cal PPC reporting form, the State will identify and evaluate for payment adjustment any PPCs that it discovers or is made of aware of through other means, including reporting of a PPC by a beneficiary, other providers, or entity communicated in any manner; any review of Medi-Cal claims performed by the State, including audits and Treatment Authorization Requests (TARs); and reviewing charts. The State will accumulate these occurrences, evaluate whether a payment was made, and examine the details regarding each occurrence. The State understands the importance of implementing the provisions of payment adjustments when they occur, regardless of the provider's intent to bill. The State will use the "Federal Voluntary Self-Disclosure Protocol" regarding the evaluation and examination of the PPCs reported in the inpatient and outpatient settings.

Reduction in payment shall be limited to identified PPCs that would otherwise result in an increase in payment and to the extent that the State can reasonably isolate for nonpayment, that portion of the payment directly related to the PPC. Medi-Cal will not reduce payment for a PPC that existed prior to initiation of treatment for that patient by that provider. If the State has not yet paid the claim to treat the PPC, the State will deny payment to the same provider for any isolated acute days to treat a PPC that was not present upon admission in excess of the medically necessary days to treat the condition for which the patient was admitted. If the State previously paid for the PPC, the State will withhold future payment to the provider in an amount equivalent to any increase in payment to treat the PPC that the provider did not identify as existing prior to initiating treatment for that patient.

For providers that the State pays using the diagnosis-related grouping (DRG) system, the State will not pay increased payment solely attributable to any PPCs not present upon admission when the department considers that the presence of HCAC diagnosis and procedure codes affect the DRG assignment and payment for the resulting DRG. The POA indicator will be utilized on the claim form and the payment will be priced through the DRG grouper software to ensure no additional payment was provided for PPCs that were not present on admission. In addition, the State may disallow payment for the inpatient claim and any other related claims subject to the department's quality

review and determination that the services provided meet the OPPC definition. In addition to identifying PPCs through the present on admission indicator, the State will also identify and evaluate for payment adjustment any PPCs that it discovers or is made of aware of through other means, including reporting of a PPC by a beneficiary, provider, or entity communicated in any manner; any review of Medi-Cal claims performed by the State, including audits and Treatment Authorization Requests (TARs) and reviews of charts.

The State will adjust Medicare crossover payments to remove additional payment for PPCs. If the Medicare crossover claim has a PPC diagnosis that was not present prior to the initiation of treatment for the patient by that provider, the State will exclude the PPC from the payment calculation when it can reasonably isolate increased payments directly attributable to the PPC.

The State may examine reported and discovered PPCs.