Provider Preventable Condition Payment Policy

Policy Statement

Neighborhood complies with all applicable laws and regulations with respect to non-payment for services identified as Provider Preventable Conditions (PPCs) that were performed after July 1, 2012.

In accordance with Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) and federal regulations at 42 CFR.447.26, Medicaid agencies are prohibited from paying providers for conditions that meet the definition of "provider preventable conditions." As such, Neighborhood Health Plan of Rhode Island (Neighborhood) does not reimburse providers for services attributed to adverse events or conditions that develop during a hospital stay. Claims for these services must be billed in a specific manner in order to not receive payment and to be reported accordingly.

Scope

This policy applies to:

☒**Medicaid**
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Definitions:

1. **Centers for Medicare and Medicaid Services (CMS):** An agency within the United States Department of Health & Human Services that is responsible for the administration of several key Federal health care programs
2. **Healthcare Common Procedure Coding System (HCPCS):** A collection of standardized codes, developed by CMS, to represent procedures, supplies, products, and services provided in the delivery of healthcare
3. **Hospital Acquired Condition (HAC):** An undesirable condition or complication developed by a patient during a stay in a hospital or medical facility
4. **INTEGRITY:** The integrated Medicare-Medicaid Plan (MMP) offered to Neighborhood members who are fully eligible for both Medicare and Medicaid benefits
5. **National Coverage Determination (NCD):** A United States nationwide determination of Medicare coverage for an item or service used for a particular medical condition
6. **Never Events:** Adverse medical events that are clearly identifiable and measurable, serious enough to result in death or significant disability, and usually preventable
7. **Present on Admission (POA):** Conditions present at the time an order for inpatient admission occurs, or that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery
8. **UB-04 (or CMS-1450**): The official standard health insurance claim form, used by institutional physicians and other providers, that is required by CMS when submitting bills or claims for reimbursement of health services to Medicare or Medicaid

Provider Preventable Conditions (PPCs) are classified into two separate categories:

1. **Hospital Acquired Conditions (HAC)**
    a. As part of the payment determination, the Centers for Medicare and Medicaid Services (CMS) has designated fourteen (14) categories of hospital acquired conditions (HAC), which are conditions not identified as present on admission (POA) on a UB-04 claim form:

Category	Examples
Foreign object retained after surgery	
Air embolism	
Blood incompatibility	
Stage III and IV pressure ulcers	
Falls and trauma	• Fractures • Dislocations • Intracranial injuries • Crushing injuries • Burn • Other injuries

Manifestations of poor glycemic control	• Diabetic ketoacidosis • Non-ketotic hyperosmolar coma • Hypoglycemic coma • Secondary diabetes with ketoacidosis • Secondary diabetes with hyperosmolarity
Catheter-associated urinary tract infection (UTI)	
Vascular catheter-associated infection	
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	
Surgical site infection following bariatric surgery for obesity	• Laparoscopic gastric bypass • Gastroenterostomy • Laparoscopic gastric restrictive surgery
Surgical site infection following certain orthopedic procedures	• Spine • Neck • Shoulder • Elbow
Surgical site infection following cardiac implantable electronic device (CIED)	
Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures	• Total knee replacement • Hip replacement
Iatrogenic pneumothorax with venous catheterization	

b. A complete list of the corresponding ICD-10 diagnosis codes by Federal government fiscal year can be found on the CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs

2. **Other Provider Preventable Conditions (OPPC) – "Never Events"**
   a. Other Provider Preventable Conditions are those serious medical mistakes that should never happen, and thus are deemed "never events." These events meet the requirements of an "other provider preventable condition" pursuant to 42 CFR 447.26(b) and include at a minimum the conditions listed below, regardless of the place of service:
      i. Wrong surgical or other invasive procedure performed on a patient
      ii. Surgical or other invasive procedure performed on the wrong body part
      iii. Surgical or other invasive procedure performed on the wrong patient

Neighborhood will not reimburse facilities or professional providers for the increased incremental costs of inpatient care or professional services that result when a Neighborhood member is harmed by any of the hospital-acquired or other preventable conditions identified on the CMS lists referenced in this document.

Specifically:

- All services provided in the operating room or other healthcare setting when an Other Provider Preventable Condition or Hospital Acquired Conditions (HAC) occurs are considered related to the HAC and, therefore, not reimbursed. All such services must be reported as HAC -related services in claims submission as described later in this publication.
- All providers in the operating room or other healthcare setting when an HAC occurs, who could bill individually for their services, are not eligible for payment, and their services must be reposted as HAC -related services.
- Any follow-up services provided as a result of a previous PPC reported by the provider involving the same member are not reimbursed and must be reported as HAC-related services.
- Related services do not include the performance of the correct procedure.

Members will assume no liability for any of the HAC or HAC-related services that are deemed nonreimbursable, to include any copays or deductibles.

Billing Guidelines

All providers must report the occurrence of a PPC to Neighborhood through claims submissions. Neighborhood must also be notified by contacting Neighborhood's Medical Management Department.

1. **HOSPITAL ACQUIRED CONDITIONS (HACs)**
    a. Inpatient facility claims containing HACs will be identified with the Present on Admission (POA) indicator. POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities. The POA indicator in conjunction with a HAC diagnosis code determines the payment implications of a claim as identified here:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. Payment will be made for the condition
N	Diagnosis was not present at time of inpatient admission. Applicable PPC payment adjustments will be made
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Applicable PPC payment adjustments will be made.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Payment will be made for the condition

1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04.

2. OTHER PROVIDER PREVENTABLE CONDITIONS

a. A non-covered claim with Bill Type 0110 must contain one of the following diagnosis codes:

ICD – 10 Code	Description
Y65.51	Performance of wrong procedure (operation) on correct patient
Y65.52	Performance of operation (procedure) on patient not scheduled for surgery
Y65.53	Performance of correct operation (procedure) on wrong side/body part

b. The applicable HCPCS modifier must be appended to all claim lines related to the incorrect surgery:

Modifier	Description
PA	Surgery Wrong Body Part
PB	Surgery Wrong Patient
PC	Surgery Wrong Patient

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
10/01/2022	Policy Review Date. Format changes, no content changes
01/06/2020	Policy Review Date. Updated to include all lines of business
11/13/2019	Policy Review Date
03/25/2019	Policy Review Date
07/01/2012	Effective Date