Payment Policy: Provider Preventable Conditions

Reference Number: DE.PP.006

Revision Log

Date of Last Revision: 03/2024 Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Disclaimer:

Delaware First Health payment policy is intended to service only as a general reference resource regarding coverage for services described. The policy does not constitute medical advice or intended to govern or otherwise influence medical advice.

Purpose:

This policy outlines Delaware First Health payment policy for **provider preventable conditions** in an inpatient setting and **never events** in all settings.

Definitions:

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.

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.

Hospital Acquired Condition (HAC): An undesirable condition or complication developed by a patient during a stay in a hospital or medical facility.

Never Events: Adverse medical events that are clearly identifiable and measurable, serious enough to result in death or significant disability, and usually preventable.

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.

UB-04: The official standard health insurance claim form, used by institutional physicians and other providers, which is required by CMS when submitting bills or claims for reimbursement of health services to Medicare or Medicaid.

CMS-1500: The official standard health insurance claim form, used by professional physicians and suppliers, which is required by CMS when submitting bills or claims for reimbursement of health services to Medicare or Medicaid.

Policy Statement:

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, Delaware First Health (DFH) 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.

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

Hospital Acquired Conditions (HAC)

- 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 infections following certain orthopedic procedures	• Spine • Neck • Shoulder • Knee • Elbow
Surgical site infection following cardiac implantable electronic device (CIED)	
Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures	• Total knew replacement. • Hip replacement
Iatrogenic pneumothorax with venous catheterization	

- 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/payment/fee-for-service-providers/hospital-aquired-conditions-hac/icd-10

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Other Provider Preventable Conditions (OPPC) – "Never Events"

- 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:
  1. Wrong surgical or other invasive procedure performed on a patient.
  2. Surgical or other invasive procedure performed on the wrong body part.
  3. Surgical or other invasive procedure performed on the wrong patient.

DFH will not reimburse facilities or professional providers for the increased incremental costs of inpatient care or professional services that result when a DFH member is harmed by any of the hospital-acquired or other preventable conditions identified on the CMS lists referenced in this document. The payment adjustments will made as part of a post-payment integrity review of claims with a HAC or Never Event Diagnosis (see Post-Payment Integrity Review below).

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 under billing requirements.
- 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 that 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 non-reimbursable, to include any copays or deductibles.

Billing Guidelines:

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

HOSPITAL ACQUIRED CONDITIONS (HACs):

- 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. **If not exempt from POA reporting, service line will deny for POA indicator required.**

NEVER EVENT - OTHER PROVIDER PREVENTABLE CONDITIONS

- A non-covered claim with Bill Type 0110 must contain one of the following diagnosis codes on a UB04:
- A non-covered claim on a CMS-1500 should also include the noted Never Event diagnosis and modifiers.

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

- 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.

FOR PROFESSIONAL CLAIMS (CMS-1500 OR 837P)

- Report a PPC by billing the procedure of the service performed with the applicable modifier:
- PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in EDI equivalent of field 24D.
- Report the Y diagnosis codes, such as Y65.51, Y65.52, or Y65.53 in EDI equivalent of field 21 [and/or] field 24E.

FOR FACILITY CLAIMS (UB-04 OR 837I)

- When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or Y codes on the claim in EDI equivalent of field 67 A – Q. Examples of ICD-10 and "Y" diagnosis codes include:
- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52;
- Surgery on wrong site Y65.53;

- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired."

INPATIENT CLAIMS

- When a PPC (defined by HAC diagnosis) is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital acquired.
- For case rate with outlier, per-diem, or percent-of-charge based hospital contracts, claims including a PPC must be submitted with the member's medical record and itemized claim data. These claims will be reviewed against the medical record and payment will be adjusted accordingly retrospectively (see post-payment integrity audit section).

Provider Preventable Conditions Process (January 1, 2023 – August 11, 2024):

- The Data-Sensitive Code (DSC) and Hospital-Acquired Conditions (HAC) Editors verifies the validity of the Present on Admission (POA) indicators and evaluates claims for Hospital-Acquired Conditions (HACs) by doing the following:
    - Checks for HAC-eligible diagnosis and procedure codes on the claim.
    - Checks for POA indicators of "N" or "U" for HAC-eligible diagnosis codes.

- If a HAC with a POA of "N" or "U" is found, the DSC editor will provide HAC information that may modify the DRG Assignment resulting in a less complex DRG impacting claim payment.
- Never Events: Cotiviti edits are in place for modifiers, PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in EDI equivalent of field 24D on CMS1500.
- Due to payment methodology differences and infrequency of providers reporting claims with the PA, PB, and PC modifier, DFH will be moving to a retrospective post-payment integrity audit effective 8/12/2024.

Retrospective (Post-Claims Payment Integrity Audit) – Effective August 12, 2024:

- DFH is obligated to ensure the effective use and management of public resources in the delivery of services to its Members. DFH does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and to the detection of preventable provider conditions, never events, and the prevention of fraud, waste, and abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of DFH, regarding payments or the recovery of potential overpayments.
- The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract, and with state and federal law.

Retrospective (Post-claims payment integrity audits) includes:

- Targeted reporting to identify claims submitted with PPCs in which the POA indicates condition was not present when the member was admitted and Never Event diagnosis.
- Medical Record /Itemized Bill Review – a Medical record and/or itemized bill will be requested to ensure claims charges do not include expenses due to a PPC or Never Event or are adjusted to exclude payment for such expenses.
- The scope of the validation will encompass any and all of the procedures and diagnosis billed by the provider.
- **Please note if medical records and itemized bill documentation are not received within the requested timeframe, DFH will recoup funds from the provider. Your failure to provide the necessary medical records and itemized bill documentation to validate billing creates a presumption that the claim as submitted is not supported by the records.**
- Any services adjusted to remove charges due to the retrospective review will reflect the following denial reasons, EX3Q – DENY: PROVIDER PREVENTABLE CONDITION.

Place of Service

Inpatient Hospital

Outpatient Hospital

Ambulatory Surgical Center

Office

Urgent Care Center

Clinic

References

https://www.cms.gov/medicare/quality/value-based-programs/hospital-acquired-conditions
https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac/icd-10
Delaware MCO Contract - Section 3.11.4 – Provider Preventable Conditions

Revision History	
3/15/2024	Initial Policy Draft

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.