Billing and Reimbursement Policy: Coding Claim Submissions for Never Events and Hospital Acquired Conditions.

Neighborhood Health Plan of Rhode Island is required by law to report all "Never Events" to the Executive Office of Health and Human Services (EOHHS) and the Rhode Island Department of Health (DOH). All providers of service are required to self report using the guidelines below as well as to the entities above (EOHHS & DOH). Required coding elements are effective for discharge dates of service after October 1, 2009. Neighborhood Health Plan of Rhode Island will be enforcing these coding requirements effective **July 1, 2012**.

Never Events: Wrong Procedure, Wrong Patient, Wrong Body Part

Requirements for Provider Billing

Hospitals are required to bill two claims when a surgical error is reported and a covered service is also being reported:

One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and

The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)

NOTE: Both the covered and non-covered claim shall have a matching Statement Covers Period.

The non-covered TOB 110 must have one of the following ICD-9- CM diagnosis codes reported in diagnosis position 2-9:

E876.5 - Performance of wrong operation (procedure) on correct patient
E876.6 - Performance of operation (procedure) on patient not scheduled for surgery
E876.7- Performance of correct operation (procedure) on wrong side/body part

Note: The above codes shall not be reported in the External Cause of Injury (E-code) field.

Outpatient, Ambulatory Surgical Centers, and Practitioner Claims

Requirements for Provider Billing

Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery(s):

PA: Surgery Wrong Body Part
PB: Surgery Wrong Patient
PC: Wrong Surgery on Patient

Summary Grid:

	CMS 1500	**UB-04**
ICD-9 Coding (position 2-9)	E876.5 E876.6 E876.7	E876.5 E876.6 E876.7
Modifiers	PA,PB or PC	PA,PB or PC
Type of Bill	N/A	110

Hospital Acquired Conditions:

Applicable Present on Admission coding is required in Boxes 67A through Q of the UB04 claim form effective **July 1, 2012**.

Inpatient Claims

Hospitals are required to report the Present on Admission (PoA) indicator for all reported ICD-9-CM diagnose codes submitted with the inpatient claim. If a listed complication or co-morbidity diagnosis is identified as not present on admission and is the only complication or co-morbidity that elevates a claim from a lower-reimbursed DRG to a higher-reimbursed DRG, the hospital will be reimbursed only for the lower-reimbursed DRG, consistent with Medicare practice.
For payments not based on DRG, Neighborhood will reduce payment consistent with Medicare practice.

For claims meeting the specifications for hospital-acquired conditions, Neighborhood will reduce or partially retract the payment to the hospital consistent with Medicare practice.

Neighborhood provides quarterly reporting of reported events to the Executive Office of Health and Human Services.

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