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## Provider Preventable Condition Policy

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### 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.

### Policy Purpose

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, and Commercial** lines of business.

### Prerequisites

All services must be medically necessary to qualify for reimbursement.

Service-specific criteria benefit limitations and prior authorizations requirements may apply. Prior authorization requirements vary by line of business and services provided. 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 Prior Authorization Reference Guide](#)
- Neighborhood’s [Clinical Medical Policies](#). In the absence of a clinical medical policy, Neighborhood utilizes industry standard evidenced-based clinical review criteria.

Please contact Utilization Management at (401) 459-6060 for additional details.

### 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:

Foreign object retained after surgery	
Air embolism	
Blood incompatibility	
Stage III and IV pressure ulcers	
Falls and trauma	<ul style="list-style-type: none"> <li>• Fractures</li> <li>• Dislocations</li> <li>• Intracranial injuries</li> <li>• Crushing injuries</li> <li>• Burn</li> <li>• Other injuries</li> </ul>
Manifestations of poor glycemic control	<ul style="list-style-type: none"> <li>• Diabetic ketoacidosis</li> <li>• Non-ketotic hyperosmolar coma</li> <li>• Hypoglycemic coma</li> <li>• Secondary diabetes with ketoacidosis</li> <li>• Secondary diabetes with hyperosmolarity</li> </ul>

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	<ul style="list-style-type: none"> <li>• Laparoscopic gastric bypass</li> <li>• Gastroenterostomy</li> <li>• Laparoscopic gastric restrictive surgery</li> </ul>
Surgical site infection following certain orthopedic procedures	<ul style="list-style-type: none"> <li>• Spine</li> <li>• Neck</li> <li>• Shoulder</li> <li>• Elbow</li> </ul>
Surgical site infection following cardiac implantable electronic device (CIED)	
Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures	<ul style="list-style-type: none"> <li>• Total knee replacement</li> <li>• Hip replacement</li> </ul>
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.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html)

## **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 non-reimbursable, 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)

- 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.

Code	Reason for Code
<b>W</b>	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.
<b>1</b>	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

## 2. OTHER PROVIDER PREVENTABLE CONDITIONS

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

ICD-9 Code	ICD-10 Code	Description
E876.5	Y65.51	Performance of wrong procedure (operation) on correct patient
E876.6	Y65.52	Performance of operation (procedure) on patient not scheduled for surgery
E876.7	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	Wrong Surgery on Patient

### 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
07/01/2012	Effective Date
03/25/2019, 11/13/2019, 01/06/20	Review Dates
03/25/2019, 11/13/2019, 01/06/20	Revision Dates