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Area	Provider Payment Policies
Lines Of Business	All Lines of Business

Never Events, Adverse Events, Hospital Acquired Conditions, Serious Reportable Conditions & Provider Preventable Conditions

Applicable Lines of Business:

✓ Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)
✓ Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO
✓ Mountain Health Trust (MHT) including WV Medicaid (Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations) and West Virginia Children's Health Insurance Program (WVCHIP)
✓ Self-Funded/Administrative Services Only (ASO)
✓ West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

Dental
✓ Facility
Pharmacy
✓ Professional

Definitions

Term	Definition
Adverse Event	Experiences with an abnormal, harmful or undesirable effect as a result of care provided in a healthcare setting.

Term	Definition
Bureau for Medical Services (BMS)	BMS is the designated single state agency responsible for the administration of the State of West Virginia's Medicaid program.
Centers for Medicare and Medicaid Services (CMS)	A federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.
Hospital Acquired Condition (HAC)	Conditions which could have reasonably been prevented; are high cost or high volume or both; result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; could reasonably been prevented through the application of evidence based guidelines; were not present on admission. The Centers for Medicare and Medicaid Services (CMS) maintains a list of hospital acquired conditions which are not eligible to increase the DRG or claim payment if the condition was not present on admission.
National Quality Forum (NQF)	The NQF sets standards, recommends measures for use in payment and public reporting systems and provides information and tools to help healthcare decision makers. NQF-endorsed measures are considered the gold standard for healthcare measurement in the United States.
Never Event	According to the National Quality Forum (NQF), never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.
Provider Preventable Conditions (PPC)	According to the Bureau for Medical Services (BMS), hospital acquired conditions not present on hospital admission, the wrong procedure performed on a patient and procedures performed on a wrong patient or body part.
Serious Reportable Event (SRE)	According the NQF, a set or compilation of serious, largely preventable, and harmful clinical events, designed to help the healthcare field assess, measure, and report performance in providing safe care.

Policy Purpose:

The purpose of this policy is to address general payment guidelines related to adverse events, hospital acquired conditions (HACs), never events, serious reportable events (SREs) and provider preventable conditions (PPCs) as defined by the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF) and the Bureau for Medical Services (BMS).

Policy Description

This policy is applicable to in-network and out-of-network providers.

Providers are not permitted to receive or retain reimbursement for inpatient or outpatient services related to never events, adverse events, HACs, SREs, or PPCs.

Providers must populate a present on admission (POA) indicator on all acute care inpatient hospital claims unless the diagnosis is exempt per CMS' "POA Exempt Diagnosis" list.

Commercial, Medicare Advantage, Mountain Health Trust (MHT), Self-Funded/ASO and WV PEIA Reimbursement Guidelines:

Reimbursement will **not** occur for the following **never events** confirmed after medical record review from The Health Plan's (THP) quality management clinical staff:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient (not limited to surgery, other examples may include a different diagnostic test or medication administered other than the one ordered)
- Foreign object retained after surgery

Equipment malfunction: No payment is made for services or complications where equipment malfunction caused the procedure to be terminated or the patient to be injured. The treatment of any injury by the same provider is also ineligible for payment.

A surgical or other invasive procedure is considered erroneously performed if it is not consistent with the correctly documented informed consent for that patient.

Emergent situations that occur during surgery for which it is not possible to obtain informed consent are not considered a never event.

Also, a never event is not intended to include changes in the plan that occurred upon surgical entry into the patient due to a discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation or the discovery of an unusual physical configuration (e.g. adhesions, spine level/extra vertebrae).

When a surgical or other invasive procedure is erroneously performed:

- All services provided in the operating room when an error occurs are considered related and therefore not covered.
- All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment.
    - This includes the surgeon, anesthesiologist, radiologist etc.
    - Operating room or procedure room reimbursement will also not occur as a result of

a wrong surgery.
    - Members will be held harmless for any payment regarding a wrong surgery.
- All related services provided during the same hospitalization in which the error occurred are not covered.
- All providers in the same group, employed by, or associated with the provider(s) who caused or created the never event or error, which could bill or may receive reimbursement for services to correct the error, are not eligible for payment.
- Subsequent services rendered by a provider not involved with the initial never event will be reimbursed.
- When the existence of an outpatient preventable serious adverse event is recognized before the patient is discharged, the facility should "not seek payment" by not submitting a claim for the services to THP and not presenting a bill to the member. The member must be held harmless.
- If the existence of an outpatient preventable serious adverse event is not recognized until after the claim for the outpatient services has been submitted and/or payment has been received, the provider should notify THP so that payment can be prevented or retracted. The member must be held harmless.

Hospital Acquired Conditions: THP will **not** provide payment to hospitals or providers for treatment of HACs **unless** the condition was present on admission.

The HAC categories below are compiled by CMS:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III or IV pressure ulcers
- Falls and trauma
    - Fractures
    - Dislocations
    - Intracranial injuries
    - Burn
    - Crushing Injuries
    - Other Injuries
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic 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 device (CEID)
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures
    - Total knee replacement
    - Hip replacement
- Iatrogenic pneumothorax with venous catheterization

Information Exclusive to Mountain Health Trust Members:

Provider Preventable Conditions: Article III, Section 2.7.8:

Exclusive to MHT members as defined by WV BMS in Section 2702(a) of the Affordable Care Act (ACA) prohibits federal financial participation (FFP) payments to states for any amounts expended for providing medical assistance for PPCs, including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

THP may not make payments for PPCs as defined by federal regulations and BMS policy in accordance with 42 CFR 438.6.

Billing Information:

When a claim is submitted that is determined to be billed for a Never Event, HAC, Adverse Event or SRE the provider will receive a denial code "SS" (Medical Review Decision, Member not Responsible) on their claim.

A Never Event, HAC, Adverse Event or SRE confirmed after medical record review from THP's quality management clinical staff will result in reduction of payment related to the occurrence of that event.

Payment will be permitted if there is a POA indicator value matched with an appropriate diagnosis code indicating the diagnosis was present on admission.

POA indicator modifiers must be provided on facility claims.

DRG based payment methods will follow the most current Medicare payment rules regarding the definition of HACs and payment adjustments will be based upon whether the condition and associated conditions were POA.

Payment reduction will be determined by the facility's contractual terms (i.e., DRG or percent off billed charges).

Under either DRG or non-DRG based reimbursement methods, if payment is reduced as a result of the presence of a HAC, the provider is **not permitted to seek payment from the member** for the difference between the reduced payment and the payment that might have been expected had the condition been present on admission.

Observation status is considered outpatient.

If a complication arises during the time frame that a patient is in observation, the complication shall be considered as present on admission due to the fact that it was present when the patient converted from observation (outpatient) to inpatient status.

Billing guidelines when a Never Event occurs during an inpatient stay:

- If a never event occurs during an inpatient stay, the provider must submit a **no-payment claim** (Type of Bill110) for the non-covered services – that is those related to the never event.
- The appropriate diagnosis code identifying the nature of the medical error must be reported.
- If the provider believes that during the same stay it also provided other services that were not related to the never event, it should submit two separate claims for the stay:
    - A no-payment claim (Type of Bill 110) for the non-covered services (those related to the never event); **and**
    - An inpatient claim (Type of Bill 11x, excluding 110) for the covered services provided (those not related to the never event).

  In this situation, the hospital must report the same **from and through dates** on both the no-payment claim and the inpatient claim. The appropriate diagnosis code for the never event must be listed on the no-payment claim only to identify the nature of the medical error. All other standard UB04 hospital claim form billing protocols apply to both the no-payment claim and the inpatient claim.

Additional billing information may be found in THP's Provider Manual located at healthplan.org "For Providers," "Resources."

Post-payment Review:

The claim and record must include documentation that reflects the criteria of this policy, and is subject to audit by THP at any time pursuant to the terms of your provider agreement.

References and Research Materials:

Centers for Medicaid and Medicare Services "Hospital-Acquired Conditions - Present on Admission Indicator - Coding" Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding

Centers for Medicaid and Medicare Services, "Hospital-Acquired Conditions - Present on Admission Indicator" Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions

National Quality Forum "Serious Reportable Events" Available at: http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

WV Department of Health and Human Services. State Plan Amendment (SPA) 12-010 of West Virginia's Title XIX State Plan Attachments 4.19-A and 4.19-B. July 19, 2013. Accessed May 10, 2022.

Policy History:

Date	Description
5/11/2022	Annual Review. Added reference for WV SPA 12-010 as well as added the document for the reference to the attachments. Reviewed criteria, references, and links for updates.

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgement. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

Attachments

Hospital-Acquired Conditions _ CMS.pdf

Hospital-Acquired Conditions Present on Admission Indicator Coding _ CMS.pdf

NQF List of SREs.pdf

SPA 12-010.pdf