Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Serious Adverse Events (Never Events & Hospital Acquired Conditions)

Policy Number: RM018
Last Review: 01/01/2025

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Serious Adverse Events (SAE) are a compilation of serious, largely preventable, and harmful clinical events, involving harm to the patient, designed by the National Quality Forum (NQF) to help the healthcare field assess, measure, and report performance in providing safe care. Centers for Medicare and Medicaid Services (CMS) has adapted a specific listing of these SAEs, commonly referred to as 'never events' and established a listing of Hospital Acquired Conditions (HAC) that are to be reported and do not warrant reimbursement.

Major Surgical 'Never Events' are serious medical errors that should not occur, are harmful to patients, and do not warrant reimbursement as they are not medically indicated; wrong patient, wrong procedure, wrong body part. A surgical or other invasive procedure is considered to be the wrong procedure, body part or patient if it is not consistent with the correctly documented informed consent for that patient. According to the NQF, 'never events' are errors in medical care that are clearly unambiguous (identifiable and measurable), preventable, serious in their consequences for patients (loss of body function, disability, loss of body part or death), and that point to a real problem in the safety and credibility of a healthcare facility. Paramount's position is in line with

CMS regarding 'never events' and therefore they will not be reimbursed.

Hospital Acquired Conditions (HAC) is an undesirable situation or condition arising during a time spent in a hospital or medical facility. HACs were adopted by CMS to motivate hospitals to accelerate improvement in patient safety, and to limit hospitals' ability to bill Medicare for complications. The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in the Medicare Severity Diagnosis Related Group (MS-DRG) payment for specified hospital-acquired conditions. Inpatient Prospective Payment System (IPPS) hospitals are not to receive the higher payment for cases when one of the designated conditions is acquired during hospitalization. The hospital is to be paid as if the diagnosis was not present.

Paramount has adopted categories of conditions that were selected by CMS to be HACs. (Refer to https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac?redirect=/hospitalacqcond/). Any future categories and/or conditions recognized by CMS as a HAC shall be deemed adopted by Paramount. When a Hospital Acquired Condition does occur, all inpatient acute care hospitals shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the claim prior to submitting for payment.

Current and valid Present on Admission (POA) Indicators (as defined by CMS) must be populated on all inpatient acute care hospital claims.

General Present on Admission (POA) Reporting is defined as conditions present at the time the order for inpatient admission occurs.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount does not reimburse for Serious Adverse Events, which includes both Never Events and Hospital Acquired Conditions, unless provider, state, federal, or CMS contracts and/or requirement indicate otherwise.

Paramount does not provide reimbursement to 'never events':

- **To any providers in the operating/procedure room when a 'never event' occurred who can bill individually for their services (e.g., surgeon, assistant, anesthesia, perfusionist, radiology, etc.)**
- **For all related services provided during the same hospitalization in which the 'never event' occurred**
- **For serious adverse events related to the 'never event' whether inpatient or outpatient**

Following hospital discharge, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

Paramount does not provide reimbursement for 'hospital-acquired conditions,' as they are largely preventable, HAC's may include (not an all-inclusive list):

- **Surgical adverse event that could have reasonably been prevented with a change in surgical technique or clinical judgment**
- **Surgical site infections on clean cases (e.g., breast biopsy)**
- **Nosocomial infections**
- **Error in the dose or administration of a drug**

HACs determined to be preventable are excluded from diagnosis related group (DRG) calculation for reimbursement purposes in accordance with this policy.

A member can never be held financially responsible for any service/procedure related to a serious adverse event.

COVERAGE CRITERIA:
Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Three (3) Major Surgical 'Never Events'
There are three major surgical 'never events' which are clearly preventable and not considered to be medically necessary. Providers should report services as described below and are expected to waive all direct and indirect related costs. Facilities and providers shall not bill for reimbursement for any of these events performed in either the inpatient or outpatient setting. Facilities and providers are required to report 'never events' by submitting a no-pay claim with the modifiers identified below.

Inpatient Hospital:
For inpatient hospitalizations involving surgical errors, hospitals must separate the hospital stay into two claims:

- One claim with medically necessary and reimbursable service(s)/procedure(s) unrelated to the erroneous surgery(s) with a Type of Bill (TOB) 11X (with the exception of 110), and
- The second claim with all services related to the never event, including all non-reimbursable service(s)/procedure(s) with a TOB 110 (no-pay claim).

Both claims must have a matching Statement Covers Period.

The no-pay Type of Bill 110 claim must have one of the following ICD-10-CM diagnosis codes reported on the claim to identify the type of erroneous surgery performed. In addition to the diagnosis listed, the claim must also append one of the listed modifiers to all services related to the 'never event'

ICD-10 CODES	Modifiers	Description
Y65.51	PC	Wrong surgery or invasive procedure on patient
Y65.52	PB	Surgical or invasive procedure on the wrong patient
Y65.53	PA	Surgical or invasive procedure on the wrong body part

Hospital outpatient, ambulatory surgical centers (ASCs) and practitioners:
In addition to reporting the applicable ICD-10-CM code to identify the erroneous surgery performed, one of the above modifiers must be appended to all lines related to the surgical error:

Note: the above diagnosis codes are not to be reported in the External Cause of Injury (E-code) field

Neither the professional provider nor facility may seek payment from the member for the non-reimbursable services. The member must be held harmless.

Hospital Acquired Conditions (HAC)
Paramount aligns with CMS on the listing of HACs, as listed below, (Refer to http://www.cms.gov/hospitalacqcond/). Any future categories and/or conditions recognized by CMS as a HAC shall be deemed adopted by Paramount. Paramount requires the identification of HACs through the submission of a Present on Admission (POA) indicator for all inpatient facility claims (see exceptions below). When a Hospital Acquired Condition does occur, all inpatient acute care hospitals shall identify the charges and/or days which are the direct result of the HAC. Current and valid Present on Admission (POA) indicators (as defined by CMS) are required for all inpatient acute care hospital primary and secondary diagnoses.

The POA indicator is not required on the admitting diagnosis. In no event shall the charges or days associated with the HAC be billed to either Paramount or our members.

General Present on Admission (POA) Reporting Requirements:
POA is defined as conditions present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

- POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- A POA Indicator must be assigned to principal and secondary diagnoses.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA Indicator would not be reported.

Indicator	Description	Payment
Y	Diagnosis was present at time of inpatient admission.	Payment is made for condition when an HAC is present
N	Diagnosis was not present at time of inpatient admission.	No payment is made for condition when an HAC is present
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment is made for condition when an HAC is present
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition when an HAC is present
1	Unreported/Not used. Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, it was determined that blanks were undesirable when submitting this data via the 4010A. NOTE: The number "1" POA Indicator should not be applied to any codes on the HAC list. Note: The number 1 is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.	Exempt from POA reporting

The presence of "N" or "U" indicate a condition was hospital acquired and therefore not eligible for reimbursement. When the POA indicator identifies a HAC; charges, diagnosis, inpatient days, complications, and comorbidities (CC) and major complications and comorbidities (MCC) will be excluded from payment calculations. Calculation of payment is based on contracted reimbursement methodology with all HAC related services excluded from that calculation.

Reimbursement will not be reduced or denied if a condition defined as a HAC for a member existed prior to the initiation of treatment by that facility. If a HAC is caused by one facility (primary), payment will not be denied to the secondary facility that treated the HAC.

CMS has identified the following 14 categories of HACs because they are (a) high cost or high volume or both (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma causing:
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burns
  - Electric Shock

- Manifestations of Poor Glycemic Control causing:
  - 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 Following:
  - Coronary Artery Bypass Graft (CABG)—Mediastinitis
  - Cardiac Implantable Electronic Device (CIED)
  - Bariatric Surgery
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following:
  - Total Knee Replacement
  - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

At the time of this publication, the following facilities are EXEMPT from the HAC payment provisions + POA indicator requirement:

- Critical Access Hospitals (CAHs)
- Long-term Care Hospitals (LTCHs)
- Cancer Hospitals
- Children's Inpatient Facilities
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities
- Veterans Administration/Department of Defense Hospitals

Documentation of the POA must come from the provider, physician, or qualified healthcare practitioner who is legally responsible for establishing the patient's diagnosis. POA information may not be gleaned from non-provider documentation such as nurses' notes, dietician reports, etc.

Neither the professional provider nor facility may seek payment from the member for the non-reimbursable services. The member must be held harmless.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 08/01/2020

Date	Explanation & Changes
08/01/2020	• Reimbursement Policy created
01/01/2024	• Reimbursement Policy reviewed and updated to reflect most current reimbursement/billing guidelines
02/01/2024	• Reimbursement/Billing Policy updated to the new policy template
01/01/2025	• Reimbursement/Billing Policy reviewed and updated to reflect the most current clinical evidence. No changes to policy statement.

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

- Centers for Medicare and Medicaid Services (CMS) National Coverage Decision (NCD) 140.6 for Wrong Surgical or Other Invasive Procedures Performed on a Patient CMS Pub 100-04 Medicare Claims Processing Transmittal 1819, Change Request 6405
- Centers for Medicare & Medicaid Services. National Coverage Determination 140.7: Surgical or Other Invasive Procedure Performed on the Wrong Body Part https://www.cms.gov/medicarecoverage-database/view/ncd.aspx?ncdid=328
- Centers for Medicare & Medicaid Services. Hospital-Acquired Conditions (Present on Admission Indicator). https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond
- Medicare National Coverage Determinations Manual Chapter 1, Part 2 (Sections 90 – 160.26) Coverage Determinations. Accessed at: www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf - 2009-07-30
- Center for Medicare & Medicaid Services. Department of Health and Human Services. Code of Federal Regulations. 42 CFR.447.26. Prohibition on payment for provider-preventable conditions. www.cms.gov.
- Centers for Medicare & Medicaid Services. Hospital-Acquired Conditions. Last revised October 3, 2019. www.cms.gov.
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions
  - https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=329
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- National Quality Forum (NQF). Never Events. Retrieved May 02, 2022, from www.cdc.gov.
- Facility Claims – IP/OP & ASC billed on UB form – Chapter 32 section 230 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf
- Professional Claims including ASC billed on a HCFA form - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R102NCD.pdf

U.S. Department of Health and Human Services: Office of the Inspector General. Adverse Events. https://oig.hhs.gov/reports-and-publications/featured-topics/adverse-events/ Published 2022.

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

National Uniform Billing Committee (NUBC) https://www.nubc.org/

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS

Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Industry Standard Review