BOSTON MEDICAL CENTER HEALTHNet PLAN
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WELL SENSE HEALTH PLAN
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Reimbursement Policy

Provider Preventable Conditions and Serious Reportable Events

Policy Number: 4.610
Version Number: 10
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Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan
☐ Well Sense Health Plan

Boston Medical Center HealthNet Plan
☒ MassHealth MCO
☒ MassHealth ACO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Consistent with state and federal guidelines, the Plan does not reimburse providers for the cost of services that are attributable to Serious Reportable Events (SREs), or Provider Preventable Conditions (PPCs). The list of PPCs and SREs in this policy are subject to change. This policy applies to events which are identified as PPCs and SREs on the date of service.

If a condition defined as a PPC or SRE existed for a member prior to the onset of treatment by a provider, no reduction in payment will be imposed on that particular provider. The Plan may limit reductions in payments to providers to the extent that (1) an identified PPC or SRE would otherwise result in an increase in payment and/or (2) it can reasonably isolate for nonpayment the portion of payment directly related to treatment for, or related to, the PPC or SRE.

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Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

Definitions

Serious Reportable Event (SRE): An event that occurs on premises covered by a hospital's license, office based practice, ambulatory surgery center, or skilled nursing facility that results in an adverse patient outcome, is clearly identifiable and measurable, usually or reasonably preventable, serious in their consequences (such as resulting in death or loss of a body part, injury more than transient loss of a body function or assault). These events are also characterized as adverse in nature, represent a clear indication of a health care provider's lack of safety systems and/or, are events that are important measures for public credibility or public accountability as established by guidelines issued by the National Quality Forum (NQF) as Serious Reportable Events (SREs).

Provider Preventable Conditions (PPCs): Conditions that meets the definition of a "Health Care Acquired Condition (HCAC)" or an "Other Provider Preventable Condition (OPPC)" as defined by the Centers for Medicare and Medicaid Services (CMS) in federal regulations at 42 CFR 447.26(b) or by the Massachusetts EOHHS.

Health Care Acquired Conditions (HCACs): Conditions occurring in any inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip-replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions (OPPCs): Conditions occurring in any health care setting and as defined in CMS federal regulations at 42 CFR 447.26(b), which are further divided into two sub-categories:

- ***National Coverage Determinations (NCDs):*** NCDs are mandatory Other Provider Preventable Conditions (OPPCs) and mean any of the following conditions that occur in any health-care setting:
  - wrong surgical or other invasive procedure performed on a patient
  - surgical or other invasive procedure performed on the wrong body part
  - surgical or other invasive procedure on the wrong patient
- ***Additional Other Provider-Preventable Conditions (OPPCs):*** Events identified by Executive Office of Health and Human Services (EOHHS) Mass Health as Additional Other Provider Preventable Conditions.

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Condition or Event	PPC HCAC	PPC OPPC	PPC NCD	SRE
Surgery or other invasive procedure performed on the wrong site			X	X
Surgery or other invasive procedure performed on the wrong patient			X	X
Wrong surgical or other invasive procedure performed on a patient			X	X
Unintended retention of a foreign object in a patient after surgery or other invasive procedure	X			X
Intraoperative or immediately postoperative/post procedure death in an ASA Class I patient		X		X
Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	X			X
Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting		X		X
Patient death or serious injury associated with the use or function of a device in patient care in which the device is used for functions other than as intended		X		X
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area		X		X
Patient death or serious injury associated with unsafe administration of blood products	X			X
Patient death or serious injury associated with a fall while being cared for in a healthcare setting				X
Artificial insemination with the wrong donor sperm or wrong egg				X
Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen		X		X
Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting		X		X

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Condition or Event	PPC HCAC	PPC OPPC	PPC NCD	SRE
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy		X		X
Pressure ulcers — stage III or IV	X			X
Unstageable pressure ulcers acquired after admission/presentation to a healthcare setting		X		X
Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results		X		X
Blood Incompatibility	X			
Manifestations of Poor Glycemic Control including the following: • Diabetic ketoacidosis • Nonketotic hyperosmolar coma • Hypoglycemic coma • Secondary diabetes with ketoacidosis • Secondary diabetes with hyperosmolarity	X			
Iatrogenic pneumothorax with venous catheterization	X			
Catheter-associated urinary tract infection (UTI)	X			
Vascular catheter-associated infection	X			
Deep vein thrombosis following a total knee replacement or hip replacement. NOT APPLICABLE TO PEDIATRIC (UNDER 21YEARS Of AGE) OR OBSTETRIC PATIENTS.	X			
Falls and trauma, including those related to fracture, dislocation, or intracranial or crushing injury	X			
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	X			
Surgical site infection following certain orthopedic procedures: • Spine • Neck • Shoulder • Elbow	X			

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Condition or Event	PPC HCAC	PPC OPPC	PPC NCD	SRE
Surgical site infection following bariatric surgery for obesity: • Laparoscopic gastric bypass • Gastroenterostomy • Laparoscopic gastric restrictive surgery	X			
Surgical Site infection following Cardiac Implantable Electronic Device (CIED) procedures	X			
Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)		X		X
Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	X			X
Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	X			X
Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances				X
Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting		X		X
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider				X
Abduction of a patient/resident of any age				X
Sexual abuse/assault on a patient or staff within or on the grounds of a healthcare setting				X
Death or serious injury of a patient or staff resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting		X		X
Patient suicide, attempted suicide, or self-harm that results in serious injury while being cared for in a healthcare setting		X		X

Condition or Event	PPC HCAC	PPC OPPC	PPC NCD	SRE
Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person				X
Patient death or serious injury associated with patient elopement (disappearance)		X		X

Provider Obligations

Member & Enrollee Rights and Responsibilities

- Providers must notify a member of the PPC/ SRE which occurred
- Providers cannot charge a member for, SREs, PPCs and any related services, including member cost sharing
- Providers will not prevent member access to services due to non-payment for PPCs/ SREs

Notification and Reporting Requirements

Providers should reference the Provider Manual for reporting requirements. The Plan requires all PPCs/SREs to be reported within seven (7) calendar days of the event to the Massachusetts Department of Public Health (DPH). For SREs/adverse events unrelated to behavioral health care, call the Plan's Quality Department at 617-478-3704 to report the event. For SREs/adverse events related to behavioral health care, call the Plan's partner, Beacon Health Strategies, at 866-444-5155 (TTY/TDD line at 866-727-9441) to report the event. The Plan may audit provider medical records at any time regarding PPCs/SREs to determine non-reporting and if identified, retract all such payments related to care rendered in support of a PPC/SRE and report such findings to state and federal agencies for further action.

Preventability Determination

Following its initial report, a provider must complete a documented preventability determination of the PPC/SRE, in accordance with State Requirements, and file an updated PPC/SRE report with the Massachusetts Department of Public Health, with a copy to the Plan and the patient, no later than 30 days after the date of the initial PPC/SRE report.

If, as a result of the preventability determination, the provider determines that the PPC/SRE was preventable, it may not bill the Plan or the member for any services directly related to:

- the occurrence of the event
- the correction or remediation of the event
- subsequent complications arising from the occurrence of the event

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The following providers are prohibited from seeking reimbursement from the Plan or member for services that are directly related to a PPC/SRE:

- a hospital at which the event occurred (including any site covered by the hospital's license)
- an ambulatory surgical center at which the event occurred
- any practitioner(s) who performed the billable procedure during which the PPC/SRE occurred

If any of the above mentioned providers previously billed and/or were paid by the Plan for these services, the providers must reimburse the Plan and/or the Plan will retract payments from the providers for the associated services.

If, as a result of the preventability determination, the provider determines that the PPC/SRE was not preventable (in whole or in part), the Plan will conduct its own preventability review and make its own determination. (The Plan may begin its preventability determination review prior to receipt of the provider's preventability determination.) If the Plan agrees with the provider, it will pay the provider for the applicable services. If the Plan disagrees with the provider and determines that the PPC/SRE was preventable (in whole or in part), the Plan will deny or retract payment (in whole or in part) from all responsible providers for the associated services. Providers may appeal the denial or retraction under the Plan's standard provider appeals procedure.

Readmissions to the same facility or follow-up care provided by the same provider(s) or a provider owned by the same parent organization are not billable if the services occur within 30 days of the discovery of the event. (Providers that accept patients previously injured by a PPC/SRE at another facility or under the care of another physician may bill and receive payment for all services provided).

Applicable Coding & Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

ICD-10 Diagnosis Coding

When reporting a PPC or SRE all providers must use an ICD-10 diagnosis code from the Y65 category (other misadventures during surgical and medical care)

Inpatient Services

The following represent the applicable providers for Inpatient Services:

UB-04 or 837I Institutional claims	CMS-1500 or 837P Professional claims
Acute Inpatient hospitals	Acute Inpatient hospital claims for Acute Outpatient hospital-based Physician services
Privately owned Chronic Disease and Rehabilitation Outpatient hospitals	
State-owned Non-Acute Outpatient hospitals operated by the Department of Public Health (DPH)	

A Present on Admission (POA) determination is required on the principal and each secondary diagnosis reported on an inpatient claim, unless the code is exempt from POA reporting per ICD-10 Official Guidelines for Coding and Reporting. The POA determination is as of the time the order for inpatient admission occurs; by definition, diagnoses associated with a preceding outpatient encounter are considered present on admission.

Present on Admission (POA) Key	
POA Indicator	**Description**
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
Blank	Exempt from POA reporting.

When a PPC/SRE occurs the hospital must submit two claims; one for the non-covered services related to a PPC/SRE and another for covered services or procedures unrelated to the PPC/SRE.

The non-covered institutional services must be submitted with a no-pay type of bill 110 and the unrelated covered services must be submitted on a separate claim with a routine type of bill 11X.

Outpatient Services

The following represent the applicable providers for Outpatient Services:

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UB-04 or 837I institutional claims	CMS-1500 or 837P professional claims
Acute Outpatient hospitals and Hospital Licensed Health Centers (HLHCs)	Acute Outpatient hospital and HLHC claims for Acute Outpatient hospital-based Physician services
Privately owned Chronic Disease and Rehabilitation Outpatient hospitals	Freestanding Ambulatory Surgery Centers (FASCs)
State-owned Non-Acute Outpatient hospitals operated by the Department of Public Health (DPH)	

The Plan requires the use of the below coding when submitting claims that contain services identified as a PPC/SRE, regardless of setting, rendering provider type, or claim form used.

Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

When a PPC/SRE occurs the provider must submit two claims; one for the non-covered services related to a PPC/SRE and another for covered services or procedures unrelated to the PPC/SRE.

The non-covered institutional services must be submitted with a no-pay type of bill 130 and the unrelated covered services must be submitted on a separate claim with a routine type of bill 13X.

Professional Services

The following represent the applicable providers for Professional Services:

CMS-1500 or 837P claims	
Oral Surgeons (Emergency only)	Radiation and Oncology treatment centers
Group Practice Organizations	Independent Diagnostic Testing Facilities (IDTF)
Independent nurse midwives	Freestanding birth centers
Independent nurse practitioners	Family planning agencies
Optometry providers	Sterilization clinics
Physicians	Community Health Centers
Podiatrists	Abortion clinics

Since HCACs and OPPCs are applicable only to hospitals and freestanding ambulatory surgery centers, all other providers should submit Professional no-pay claims only for services directly related to NCDs. Providers should include appropriate modifier from table above.

Follow up Care Services

Any follow up care that is medically necessary and billed by the same provider that is related to the event is not covered and should also be billed as described above.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
10/24/2011	01/01/2012	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
06/15/2012	review	06/15/2012	Payment Policy Committee
06/25/2012	Revision of Serious Reportable Events Policy	06/25/2012	Payment Policy Committee
11/23/2012	OPPCs previously identified by EOHHS	11/23/2012	Payment Policy Committee
01/11/2013	Reformatted order and edited Provider Obligations	01/11/2013	Payment Policy Committee
12/02/2013	Updated template and product applicability section for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare	12/02/2013	Payment Policy Committee
01/15/2014	Removed ICD-9 coding	01/15/2014	Payment Policy Committee
02/24/2015	Annual review, new template, removed Commonwealth Choice, Commonwealth Care	04/01/2015	Payment Policy Committee
04/16/2019	Annual review; new logos and product applicability box, updated PPC/SRE table, added ICD-10 diagnosis requirements.	07/01/2019	Payment Policy Committee
06/15/2021	Annual Review, formatting changes	07/01/2021	Payment Policy Committee

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Other Applicable Policies

- Free Standing Surgical Facility Services , 4.114
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Inpatient Hospital, 4.112
- Outpatient Hospital, 4.17
- Dental Services, 4.15
- Physician and Non Physician Practitioner Services, 4.608

References

- CMS- Hospital Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals-Overview; ICN #901045.
- CMS – Letter to State Medicaid Directors, SMDL # 08-004, July 31, 2008
- CMS- Present on Admission (POA) Indicator reporting by Acute Inpatient Prospective Payment System (IPPS) Hospital; ICN # 901046.
- Massachusetts General Law (M.G.L.), Chapter 305 of the Acts of 2008
- 42 CFR § 434.6(a)(12) - General requirements for all contracts and subcontracts
- MassHealth All Provider Manuals Appendix U
- MassHealth All Provider Manuals Appendix V
- 42 CFR 438.3(g) – Standard contract requirements - Provider-preventable condition requirements
- 42 CFR 447.26(b): Prohibition on payment for provider-preventable conditions
- NQF Updated SRE Release – June 13, 2011
- *HealthyMass* Serious Reportable Events Task Force Policy Guidelines
- Massachusetts General Law (M.G.L.), Chapter 305 of the Acts of 2008

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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