Commercial Reimbursement Policy

Subject: **Provider Preventable Conditions – Professional and Facility**	
Policy Number: **C-23002**	Policy Section: **Administration**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan does not reimburse for Provider Preventable Conditions (PPC), formerly known as, Preventable Adverse Events (PAE) unless provider, state, or federal contracts and/or mandates indicate otherwise. PPCs are defined as the following:

- Hospital Acquired Conditions (HAC)
- Major Surgical Never Events

Hospital Acquired Conditions (HAC)

The Health Plan requires the identification of HACs (see Exhibit B) through the submission of a Present on Admission (POA) indicator (see Exhibit A) for all diagnoses on inpatient facility claims billed on a UB-04, as identified by CMS. If the POA indicator identifies an HAC, the reimbursement for the episode of care may be reduced or denied, as outlined below.

POA indicators are required for all inpatient primary and secondary diagnoses. Failure to include the POA indicator with the primary and secondary diagnosis codes may result in the claim being denied or rejected. The POA indicator is not required on the admitting diagnosis.

If the POA indicator identifies a HAC, such charges and/or days shall be removed from the claim when calculating the DRG reimbursement for inpatient hospital services. It is possible to have more than one complication or comorbidity (CC), or major complication or comorbidity (MCC) reported on the claim. Only CCs or MCCs that are identified as HACs will be excluded when calculating the DRG. When this occurs and the CC or MCC is not one of the HACs a higher paying DRG may be assigned. Non-DRG based reimbursement may also be reduced because of the presence of a HAC.

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.

Any future categories and/or conditions recognized by CMS as a HAC or changes to the grouper algorithm shall be deemed adopted by the Health Plan.

Major Surgical "Never Events"
The Health Plan identifies Major Surgical Never Events as a surgical or other invasive procedure, or for services related to a particular surgical or other invasive procedure when a surgical procedure is erroneously performed, and/or retention of a foreign object in a patient after surgery or other procedure. For professional providers and facilities, procedures identified as a Never Event" and all related services will be rejected or denied.

The Health Plan defines Never Events as:

- Surgical or invasive procedure on the wrong body part
- Surgical or invasive procedure on the wrong patient
- Wrong surgery or invasive procedure on patient
- Retention of a foreign object in a patient after surgery or other procedure

The health plan reserves the right to adopt any procedures recognized by CMS as Never Events.

NOTES:

- Neither the professional provider nor facility may seek payment from the member for the non-reimbursable services related to a PPC. The member must be held harmless.
- The Health Plan reserves the right to request additional records from the professional provider or facility to support documentation submitted for reimbursement of a PPC. Claims may be subject to clinical review for appropriate reimbursement consideration.
- The PC modifier is defined as "Wrong Surgery on a Patient." It should not be used to represent the Professional Component of a service. Claims that incorrectly use the PC modifier may be denied. Claims must be resubmitted as a corrected claim and indicate the appropriate coding for the service(s) rendered.

Related Coding

Description	Modifier	ICD-10 Diagnosis
Surgical or invasive procedure on the wrong body part	PA	Y65.53
Surgical or invasive procedure on the wrong patient	PB	Y65.52
Wrong surgery or invasive procedure on patient	PC	Y65.51
Standard correct coding applies		

Policy History

04/01/2024	Initial approval 04/01/2024 and effective 07/01/2024: retired policy Preventable Adverse Events - Facility (C-10002) and adapted language to create a new blended policy for professional and facility providers

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Federal Register 76 FR 32815
- Optum EncoderPro 2023

Definitions

Hospital Acquired Condition (HAC)	Medical conditions or complications that were not present when a patient was admitted to the hospital but develop as a result of an error or accident that occurred during the hospital stay.
Other Provider Preventable Conditions (OPPC) aka Major Surgical "Never Events"	Procedures identified as surgical or other invasive procedure, or for services related to a particular surgical or other invasive procedure when a surgical procedure is erroneously performed • Surgery performed on the wrong patient • Surgery performed on the wrong body part • Wrong surgery performed on a patient Retention of a foreign object in a patient after surgery or other procedure
General Reimbursement Policy Definitions	

Related Policies and Materials

None

EXHIBIT A: Present on Admission Indicators and Description

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.

U	Documentation is 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.
1	This code is the equivalent of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 00410A. 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.

EXHIBIT B: Hospital Acquired Condition Categories*

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and trauma**
6. Manifestations of poor glycemic control
    a. Diabetic Ketoacidosis
    b. Nonketotic Hyperosmolar Coma
    c. Hypoglycemic Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-associated Urinary Tract Infection (UTI)
8. Vascular catheter-associated infection
9. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG))
10. Surgical Site Infection Following Bariatric Surgery for Obesity
    a. Laparoscopic Gastric Bypass
    b. Gastroenterostomy
    c. Laparoscopic Gastric Restrictive Surgery
11. Surgical Site Infection Following Certain Orthopedic Procedures
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
12. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
    a. Total knee replacement
    b. Hip replacement
14. Iatrogenic Pneumothorax with Venous Catheterization

** Includes all injuries related to falls and trauma

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date

that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.