BlueCross BlueShield of North Carolina MEDICARE

Reimbursement Policy	
Subject: **Provider Preventable Conditions**	
Policy Number: **G-20003**	Policy Section: **Administration**
Last Approval Date: **03/22/2023**	Effective Date: **03/22/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Medicare Advantage covered the service for the Healthy Blue + Medicare℠ (HMO-POS D-SNP) 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, Blue Cross NC Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Blue Cross NC Medicare Advantage strives 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, we will publish the most current policy to the website.

Policy

Blue Cross NC Medicare Advantage does not reimburse for Provider Preventable Conditions (PPC)unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. PPCs are defined as the following:

- Hospital Acquired Conditions and Health Care-Acquired Conditions (both referred to in this document as Health Care Acquired Conditions (HCAC))
- Other Provider Preventable Conditions

Health Care Acquired Conditions

Blue Cross NC Medicare Advantage requires the identification of HCACs (see Exhibit C) through the submission of a Present on Admission (POA) indicator (see Exhibit A) for all diagnoses on inpatient facility claims as identified by CMS. 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 HCAC, 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 HCACs will be excluded when calculating the DRG. When this occurs and the CC or MCC is not one of the HCACs, a higher paying DRG may be assigned. Non-DRG based reimbursement may also be reduced as a result of the presence of a HCAC. Blue Cross NC Medicare Advantage reimburses using the CMS Medicare Severity-Diagnosis Related Grouper (MS-DRG) algorithm.

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

Any future categories and/or conditions recognized as a HCAC by CMS or the state, or changes to the grouper algorithm shall be deemed adopted by Blue Cross NC Medicare Advantage.

Other Provider Preventable Conditions (OPPC)

Blue Cross NC Medicare Advantage identifies OPPCs 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. For professional providers and facilities, procedures identified as an OPPC, and all related services will be rejected or denied.

Blue Cross NC Medicare Advantage defines OPPCs in accordance with Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements, categorized 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

Providers should use the appropriate codes to report OPPCs. Erroneous surgical events occurring during an inpatient stay should be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the surgery. All other inpatient procedures and services should be submitted on a separate claim. A condition defined as an OPPC for a member existing prior to the initiation of treatment by another provider will not impact that provider's reimbursement.

Blue Cross NC Medicare Advantage reserves the right to adopt any procedures recognized by CMS as Other Provider Preventable Conditions.

Notes:

- Neither the professional provider nor facility may seek payment from the member for the nonreimbursable services related to a PPC. The member must be held harmless.
- Blue Cross NC Medicare Advantage 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. Denied claims may be resubmitted as a corrected claim and are required to include the appropriate coding for the service(s) rendered.

Related Coding		
Description	**Modifiers**	**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	
03/22/2023	Review approved and effective; minor language changes, clarified language on HCAC algorithm; policy templated updated
01/01/2021	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Code of Federal Regulations (CFR) Subpart A-Payments §447.26 • Federal Register Vol. 76, No. 108- A. The Medicare Program and Quality Improvements Made in the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) and E. Section 2702 of the Affordable Care Act • Optum EncoderPro 2023 • State contract

Definitions	
Health Care-Acquired Conditions (HCAC)	Medical conditions or complications that were not present when a patient was admitted to the hospital but develop because of errors or accidents that occurred during their 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.
General Reimbursement Policy Definitions	

Related Policies and Materials
Claims Requiring Additional Documentation
Claims Submission – Required Information for Facilities
Claims Submission – Required Information for Professional Provider
Documentation Standards for Episodes of Care
Global Surgical Package

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	Unreported/Not used. Exempt from POA reporting. 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.

EXHIBIT B: MEDICARE-EXEMPT FACILITIES

The following facilities are exempt from the reporting requirement as indicated; this applies to Medicare and Medicaid markets using Medicare methodology:

- Critical Access Hospitals (CAHs)
- Long-Term Acute Care hospitals (LTACs)
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical health care institutions
- Veterans Administration/Department of Defense hospitals

EXHIBIT C: Health Care-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

**DVT/PE following total knee replacement or hip replacement in pediatric and obstetric patients is excluded from HCAC for Medicaid.