LifeWise Assurance Company

Payment Policy

cmi_114821

Title	**Serious Adverse Events – Inpatient Facility Services**		
Number	**CP.PP.418.v2.2**		
Last Approval Date	10/03/24	**Original Effective Date**	01/11/10
Cross Reference			

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define the Plan's limitation on reimbursement of the conditions identified as Serious Adverse Events that are submitted on a UB-04/CMS-1450 paper claim form or an 837I electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Definitions	**Acute Care Inpatient Hospital -** a facility licensed or otherwise certified in the State in which it operates to provide acute inpatient services by the state agency with authority over such licensure or certification. **Adverse -** a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable. **Event -** a discrete, auditable, and clearly defined occurrence. **Preventable -** an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure. **Serious -** an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility or, when referring to other than an Adverse Event, an event which is not a trivial occurrence. **Never Event -** an Adverse Event that is serious, preventable, and of concern to both the public and healthcare provider for the purpose of public accountability. Never Event refers to three specific ICD-10-CM diagnosis occurrences on a list of inexcusable outcomes in a healthcare setting. This is a specific term known by all acute care inpatient hospitals and is also known as a wrong surgical procedure. CMS has mandated that these events will not be paid. **Hospital Acquired Condition (HAC) -** a new medical condition as identified by an ICD-10-CM diagnosis code that occurred once a patient is admitted into the hospital that could have reasonably been prevented using evidence-based guidelines. These are captured on claims using a Present-On-Admission (POA) Indicator of N or U. Although there is a universe of HACs defined by the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF), there is a specific list of diagnosis codes that CMS will not reimburse. The Plan follows the specific list of HACs as established/identified by CMS.

	Serious Adverse Events - includes both Never Events and Hospital Acquired Conditions. The events match CMS Events and are required to be reported by all licensed healthcare facilities. The Plan elected to mirror CMS in terms of the list of HACs and wrong surgeries and the ICD-10-CM codes used to identify these events.
Policy	**Hospital Acquired Conditions (HACs) and Never Events** The Plan will not reimburse a HAC that is found on the current CMS list of HACs (see link below) and is associated with a POA indicator of N or U. The Plan will also not reimburse a Never Event as defined by the ICD-10-CM diagnosis codes noted in the Codes/Coding Guidelines section of this policy. A principal diagnosis code establishing the chief reason for the inpatient admission and all corresponding conditions that coexist at the time of admission, develop subsequently or which affect the treatment received during the length of stay are required on all acute care inpatient claims to determine if a HAC or Never Event has occurred. Such diagnosis codes are required per official coding guidelines found in the current ICD-10-CM Diagnosis Codebook. All participating acute care inpatient hospitals are not allowed to receive or retain any reimbursement and are required to hold members harmless for any inpatient services related to CMS identified HACs and Never Events diagnosis codes. An official list of HACs from CMS can be found at the following link (LINK) **Present on Admission (POA) Indicators** Facilities are required to bill a POA Indicator on their submitted claims, particularly for any HAC diagnosis code. A POA Indicator is assigned to the principal and any supporting subsequent diagnoses and external cause of injury codes. Official ICD-10-CM coding guidelines on the correct coding of POA Indicators can be found in the Official ICD-10-CM Coding Guidelines, Appendix I. See the "Codes/Coding Guidelines" section in this policy for a list of POA Indicator Codes and a link to identify codes that do not require the use of a POA Indicator.
Codes/Coding Guidelines	**Never Events:** Never Events are defined by the inclusion of one of the following ICD-10-CM diagnosis codes on a submitted claim: **Y65.51:** Performance of wrong procedure (operation) on correct patient **Y65.52:** Performance of procedure (operation) on patient not scheduled for surgery **Y65.53:** Performance of correct procedure (operation) on wrong side/body part **Present on Admission (POA) Indicators:** POA Indicator codes to be used per this policy include:

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<tr><th>POA Indicator Code</th><th>Reason for Code</th></tr>
<tr><td>Y</td><td>YES; Diagnosis was present at the time of inpatient admission.</td></tr>
<tr><td>N</td><td>NO; Diagnosis was not present at the time of inpatient admission.</td></tr>
<tr><td>U</td><td>UNKNOWN; Documentation insufficient to determine if the condition was present at the time of inpatient admission.</td></tr>
<tr><td>W</td><td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.</td></tr>
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A current listing of ICD-10-CM diagnosis codes that are exempt (POA = 1) or do not require a POA Indicator can be found on the CMS website (LINK).
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<tr><td>Violations of Policy</td><td>Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan’s sole discretion.

Violations of this policy may be grounds for corrective action, up to and including termination of employment.</td></tr>
<tr><td>Exceptions</td><td>Veteran Administration (VA) hospitals are nationally excluded from this requirement.</td></tr>
<tr><td>Laws, Regulations & Standards</td><td></td></tr>
<tr><td>References</td><td>• Centers for Medicare and Medicaid Services (CMS) listing of ICD-10-CM “Hospital Acquired Conditions (HAC)”
• Centers for Medicare and Medicaid Services (CMS) current listing of “Present on Admission (POA) Indicator Exempt List”
• Centers for Medicare and Medicaid Services (CMS), Publication 100-04 Claims Processing Manual, Chapter 32-Billing Requirements for Special Services, Section 230-Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient
• ICD-10-CM Official Guidelines for Coding and Reporting, Appendix I “Present on Admission Reporting Guidelines”</td></tr>
<tr><td>Policy Owner Review</td><td>Payment Integrity Oversight Committee</td></tr>
<tr><td>Contact</td><td>Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.</td></tr>
<tr><td>Annual Review Dates</td><td>10/03/24; 01/16/24; 02/08/23; 03/04/22; 03/23/21; 04/01/20; 05/03/19; 08/09/18; 10/19/17; 10/19/16; 10/25/15; 10/26/14; 11/03/13, 11/12/12; 12/01/11; 12/02/10</td></tr>
<tr><td>Version History</td><td>08/09/18</td><td>Revised the Policy section for clarity; created new section “Code/Coding Guidelines” and moved all codes into the new section</td></tr>
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This policy was published on October 8, 2024

	05/03/19	Deleted reference to ICD-9 CM Diagnosis codes; Deleted reference and exception for acute care hospitals which could not attach a POA indicator, and the form links previously used. No longer an exception.
	04/01/20	Removed the sections concerning "External Cause of Injury Codes" section since this information was related to ICD-9 CM Diagnosis codes which have been replaced by ICD-10-CM coding guidelines
	03/23/21	• Clarified in the Purpose statement that the policy applies to facility services billed on a UB-04/CMS-1450 paper claim form or 837I electronic claim form. • Added clarification to the definitions “Never Event” and “Hospital Acquired Conditions”. • In the Policy section, expanded the second paragraph in the section “Hospital Acquired Conditions (HAC) and Never Events” and revised the “Present on Admission (POA) Indicators” paragraphs. • In the Codes/Coding Guidelines section, removed the ICD-10-CM diagnosis code T81.500A.
	03/04/22	• In the Hospital Acquired Condition section of the Policy, clarified that the Plan will not reimburse diagnosis codes on the CMS HAC list or a Never Event diagnosis code. • In the Present on Admission section of the Policy, identified where to find the coding guidelines for POA indicators. • In the Codes/Coding Guidelines section of the Policy, minor revisions to the Present on Admission Indicator code descriptions
	02/08/23	Annual review; no changes
	01/16/24	Annual review; no changes
	10/03/24	In the Hospital Acquired Conditions (HACs) and Never Events section of the Policy, revised the third paragraph to indicate members are held harmless and added a link to the CMS listing of HACs.