NEVER EVENTS AND HOSPITAL ACQUIRED CONDITIONS
Corporate Payment Policy
New Policy Effective January 2020
APPROVED October 2019

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Document Precedence

The Blue Cross and Blue Shield of Vermont ("BCBSVT") Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Plan's claim editing solution, the Plan's claim editing solution takes precedence.

Payment Policy

Description

BCBSVT encourages hospitals to reduce the likelihood of Hospital-Acquired Conditions (HAC), Never Events (NE), and related readmissions as these injuries or illnesses incurred during, or as a direct result of, a member's stay are largely preventable.

HACs are defined by The National Quality Forum (NQF) as conditions "which could reasonably have been prevented through application of evidence-based guidelines."[1] A Hospital-Acquired Condition is not

[1] Centers for Medicare & Medicaid Services, "Hospital-Acquired Conditions," https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html (last visited October 1, 2019).

present when the patient is admitted to the hospital but is present during the course of the hospital stay or at discharge. A condition may be present at discharge even if the patient does not know the condition exists or does not manifest symptoms until a later date.

There are 14 categories of HACs[2]:

1. Foreign object retained after surgery.
2. Air embolism.
3. Blood incompatibility.
4. Pressure ulcer stages III & IV.
5. Falls and Trauma including fracture, dislocation, intracranial injury, crushing injury, burn, and other injuries.
6. Catheter-associated urinary tract infection (UTI).
7. Vascular catheter-associated infection.
8. Manifestation of poor glycemic control, including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemia coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity.
9. Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG).
10. Surgical site infection following certain orthopedic procedures (spine, neck, shoulder, or elbow).
11. Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery).
12. Surgical site infection following cardiac implantable electronic device (CIED).
13. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures (total knee replacement or hip replacement).
14. Iatrogenic pneumothorax with venous catherization.

NEs are defined by the NQF as one of the following scenarios[3]:

1. Surgical Events
    a. Surgery performed on the wrong body part
    b. Surgery performed on the wrong patient
    c. Wrong surgical procedure on a patient
    d. Unintended retention of a foreign object in a patient after surgery or other procedure
    e. Intraoperative or immediately post-operative death in a normal health patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)
2. Product or Device Events
    a. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility

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[2] Centers for Medicare & Medicaid Services, "Hospital-Acquired Conditions," https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html (last visited October 1, 2019).

[3] Centers for Medicare & Medicaid Services, Newsroom, Fact Sheet: "Eliminating Serious, Preventable, and Costly Medical Errors – Never Events" (Appendix 2), https://www.cms.gov/newsroom/fact-sheets/eliminating-serious-preventable-and-costly-medical-errors-never-events (May 18, 2006); National Quality Forum, "Serious Reportable Events," http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx (last visited October 1, 2019).

   b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
   c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
3. Patient Protection Events
   a. Discharge or release of a patient or resident, of any age, who is unable to make decisions, to other than an authorized person
   b. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours
   c. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
4. Care Management Events
   a. Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   b. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
   c. Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility
   d. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
   e. Death or serious injury of a neonate associated with labor and delivery in a low-risk pregnancy
   f. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
   g. Artificial insemination with the wrong donor sperm or wrong egg
   h. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   i. Patient death or serious disability due to spinal manipulative therapy
   j. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
5. Environmental Events
   a. Patient death or serious disability associated with an electronic shock while being cared for in a healthcare facility
   b. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
   c. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
   d. Patient death associated with a fall while being cared for in a healthcare facility
   e. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
6. Radiologic Events
   a. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area
7. Criminal Events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider

b. Abduction of a patient of any age
c. Sexual abuse/assault on a patient within or on the grounds of a healthcare facility
d. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

Policy

BCBSVT identifies through claims, audits, quality of care (QOC) complaints, and case management the potential of a NE or HAC or readmissions due to complications arising from a previous surgery or admission. BCBSVT collects and reviews all matters related to quality of care received about providers.

Upon identification of a potential NE or HAC, BCBSVT's quality department will be notified immediately through the quality of care risk investigation process. See BCBSVT's QOC and Risk Investigations Policy for more information on that process. Providers must cooperate fully with QOC investigations, which cooperation includes providing all documentation, policies, and procedures that BCBSVT requests. The quality department will use the results of those investigations to encourage or require changes to reduce the likelihood of similar future events. Provider participation in performance improvement activities resulting from such investigations is an obligation of the provider's contract.

BCBSVT may also recover or make adjustments to payments when appropriate and consistent with applicable contracts, laws, and regulations. In general, BCBSVT does not pay for costs associated with treatment for an HAC, as defined in this policy, and BCBSVT does not pay for NEs, as defined by this policy. Providers must hold BCBSVT members harmless for any costs associated with NEs, and for any costs related to treatment for an HAC.

Not Eligible for Payment

BCBSVT does not pay for costs associated with treatment for an HAC, as defined in this policy.

BCBSVT does not pay for NEs, as defined in this policy.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP)

Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Inter Plan Programs (IPP)

In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Provider Billing Guidelines and Documentation

Facilities must populate the Present on Admission (POA) indicator on all claims for admissions when processing a claim associated with a NE or HAC. The POA indicators are listed in Table 1, immediately below.

Table 1. POA Indicator Values

POA Indicator	Description	Payment Status
Y	Diagnosis present at the time of inpatient admission	Eligible for payment
N	Diagnosis not present on inpatient admission	Claim will be audited to determine if payment is non-compliant
U	Documentation insufficient to determine if condition was present at time of inpatient admission	Claim will be audited to determine if payment is non-compliant
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Eligible for payment
blank	Facility exempt from POA reporting	Eligible for payment

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate

payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Eligible Providers

This policy applies to all clinical settings where patients receive care, including, but not limited to, office-based practices, ambulatory surgery centers, skilled nursing facilities, and hospitals.

Employer Group Exclusion(s)

N/A

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

N/A

Related Policies

Quality of Care (QOC) and Risk Investigations Policy
Complaints Policy
Credentialing Policy
Facility Credentialing Policy
Accessibility and Provider Administration Service Standards Policy
Provider Contract Termination Policy
Clinical Practice Guidelines Policy
Medical and Treatment Records Standards Policy
CPP_21 BCBSVT Payment Policy Preventable Readmissions

Policy Implementation/Update Information

New payment policy effective January 1, 2020 (prior version of policy was a quality improvement policy)

Approved by **Date Approved: 10/22/19**

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