Medical Coverage Policy

Payment Adjustments for Error, Hospital Acquired Conditions and Readmissions Related to Complications-PREAUTH

☐ Device/Equipment ☐ Drug ☐ Medical ☐ Surgery ☐ Test ☒ Other

Effective Date:	8/21/2012	Policy Last Updated:	8/21/2012

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

Description:

Value based payment principles require:

1. There be no payment for services that are performed in error.
2. Payment should not be increased to address the costs of complications that are generally preventable.

In the first instance, an error has occurred and de facto the standards of care have been violated. In the second instance, the care may have been entirely appropriate and the payment policy reflects a goal of not "rewarding" complications that are generally preventable, whether or not the complication was preventable in the specific case.

Payment policy is distinct from requirements of providers to report certain events to patients, accreditation agencies, regulators and/or payers and to participate in quality assurance review. It is also distinct from requirements Blue Cross & Blue Shield (BCBSRI) may have to report events to the Centers for Medicare and Medicaid Services, although in both cases the conditions or events that prompt reporting or payment adjustment may be very similar or identical.

These events may or may not result in BCBSRI performing quality of care or other review. Such review is distinct and is not a review for payment. In most cases, chart review for these adjustments is limited to verification of the event or DRG validation. In the event of readmissions, chart review will be performed to verify that the Hospital Acquired Condition (HAC)/complication is consistent with an event related to the initial admission and as defined below in criteria for these types of adjustments. These reviews are to implement a payment policy and are not to establish that standards of care were or were not met.

Payment policy is dependent upon the type of event as is detailed below.

Medical Criteria:

Not applicable this is a reimbursement policy.

Policy:

Type of Event

Error: No payment is made for error. Payment is denied for the erroneously performed service and the treatment of complications, if any, that are related to it when performed by the same provider/system. This includes the following events:

- Wrong Site Surgery
- Wrong Procedure Performed (not limited to surgery, e.g. a different diagnostic test is performed or medication administered other than the one ordered)
- Wrong Patient
- Foreign Object Retained After Surgery

Equipment Malfunction: No payment is made for services or complications where equipment malfunction caused the procedure to be terminated or the patient to be injured. The treatment of any injury by the same provider is also ineligible for payment.

Hospital Acquired Conditions (HAC): DRG based payment methods will follow the most current Medicare payment rules regarding the definitions of HAC's and payment adjustments based upon whether the condition and associated conditions were present on admission (POA). POA indicator modifiers shall be provided on facility claims. For patients who are admitted to Observation status and converted to Inpatient status, the complication shall be considered not present on admission if it arose during the observation period. The complication may or may not be related to a failure to meet usual standards of care. The most current information on Hospital Acquired Conditions can be found on the CMS Website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html

Readmissions Related to Complications: Readmissions, when related to complications, to the same or same health system facility within 30 days will be treated as if the complication occurred during the initial stay and the complication is one that would be a HAC if present during the initial stay. Additionally, the following HACs will be treated in the same manner even if there was no evidence of the complication(s) at discharge:

- Surgical Site Infections
- Deep Venous Thrombosis and/or Pulmonary Embolism (unless the patient was discharged on anticoagulants or anticoagulation was contraindicated and documented as such at discharge) and the readmission is within 7 days
- Vascular Catheter Associated Infection when the catheter is placed during the inpatient stay and the readmission occurs within 3 days of discharge and there is no evidence that the patient tampered with the catheter.

- catheter associated Urinary Tract Infection (UTI) when the patient is discharged with an indwelling catheter and there is no documentation of a compelling need (e.g. retention, palliative care) for the catheter at discharge and the readmission occurs within 3 days of discharge.

The complication may or may not be related to a failure to meet usual standards of care, except as noted above. The principle is that readmissions will be considered part of a continual care episode.

Provider Status

Payment adjustments may be to facility payment, professional payment or both. The HAC adjustments (including those related to readmissions) are applied to facility DRG payments. Equipment failure will result in adjustments for the party that receives payment related to the provision of the equipment, which is the professional when the service is performed in a non-facility setting or is the facility when performed in a facility. Wrong site surgery/wrong patient/wrong surgical procedure adjustments would apply to the facility, surgeon and anesthesia professionals as all are responsible for such events and adjustments would occur, however physicians who are not part of the surgical team (or in the same group) who provide post-operative services would not be affected. Other wrong procedure adjustments will reflect the source of error (e.g., if a medication is administered that was not ordered, the facility, not the physician payment would be affected).

A hospital system is defined as any provider that is in a system defined by contractual status with BCBSRI, facility licensure, articles of incorporation or other legal documents and includes wholly owned subsidiaries.

Disagreement by Provider with BCBSRI Adjustment

These adjustments will be implemented by the BCBSRI Audit Recovery. Contractual provisions related to Audit Recovery will apply. For providers without such provisions, administrative appeal procedures apply.

Member Liability/Cost Sharing

All adjustments are to contractually allowed amounts. If as part of risk management or other procedures a facility elects to forego collection of amounts required by member cost sharing provisions to a greater extent than required by this policy, the provider will not be considered in violation of contractual agreements.

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for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.