MassHealth Provider Preventable Conditions Payment Policy

Policy

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR.447.26, Medicaid providers must report Provider Preventable Conditions (PPCs) to Medicaid agencies, and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements. MassHealth implemented policies that conform to the federal requirements on PPCs, effective for dates of service on or after July 1, 2012. The Plan is implementing the same policies for services provided to Plan members enrolled through MassHealth.

Definitions

Provider Preventable Conditions (PPCs) are conditions that meet the definition of a "health care-acquired condition" or an "other provider preventable condition" as defined by the Centers for Medicare & Medicaid Services (CMS) in federal regulations at 42 CFR.447.26(b).

Health Care Acquired Conditions (HCACs) are conditions occurring in an inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip-replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions (OPPCs) are conditions that meet the requirements of an "other provider preventable condition" pursuant to 42 CFR.447.26(b). OPPCs may occur in any health-care setting and are divided into two sub-categories:

a) National Coverage Determinations (NCDs) - NCDs are mandatory OPPCs under 42 CFR. 447.26(b) and mean any of the following conditions that occur in any health-care setting:
    (i) Wrong surgical or other invasive procedure performed on a patient.
    (ii) Surgical or other invasive procedure performed on the wrong body part.
    (iii) Surgical or other invasive procedure performed on the wrong patient.

    For each of (i) through (iii) above, the term "surgical or other invasive procedure" is as defined in CMS Medicare guidance on NCDs.

b) Additional Other Provider Preventable Conditions (Additional OPPCs) - Additional OPPCs are state-defined OPPCs that meet the requirements of 42 CFR. 447.26(b). Certain MassHealth providers will be subject to Additional OPPCs designated by MassHealth.

Reimbursement

The Plan will not pay for PPCs that occur when the provider was providing treatment to the member, or that are PPC-related services that the provider reports through claims submissions.

- All services provided in the operating room or other health-care setting when an NCD occurs are considered related to the NCD and, therefore, not reimbursed. All such services must be reported as NCD-related services in claims submissions as described below.
- All providers in the operating room or other health-care setting when an NCD occurs, who could bill individually for their services, are not eligible for payment, and their services must be reposted as NCD-related services.
- Any follow-up services provided as a result of a previous PPC reported by the provider involving the same member are not reimbursed and must be reported as NCD-related services.
- Related services do not include the performance of the correct procedure.

Providers are prohibited from charging members for NCDs and NCD-related services that are deemed non-reimbursable, including copayments or deductibles.

Referral/notification/prior authorization requirements

Providers must report the occurrence of an NCD and all NCD-related services through claims submissions.

Massachusetts Department of Public Health (DPH)-licensed hospitals or Freestanding Ambulatory Surgery Centers (FASCs) must continue to report the occurrence of the PPC as a Serious Reportable Event (SRE) to DPH, and perform the documented review process as set forth in, and in accordance with, DPH regulations at 105 CMR 130.332 (B) and (C) (or 105 CMR 140.308 (B) and (C), as applicable). The DPH-licensed hospital or FASC must also notify the Plan by calling Provider Services at 1-866-275-3247, prompt 4, and provide the Plan with copies of the initial and follow up SRE reports as described in the Plan's *Serious Reportable Events Payment Policy*.

Billing/coding guidelines

Inpatient hospitals:
The following instructions apply to inpatient hospital providers (UB-04 or 8371 claims) and acute inpatient hospital providers billing for acute inpatient hospital-based physician services (CMS-1500 or 837P), as indicated below.

UB-04 or 837I institutional claims:	CMS-1500 or 837P professional claims:
• Acute inpatient hospitals	• Acute inpatient hospital claims for acute inpatient hospital-based physician services
• Privately-owned chronic disease and rehabilitation inpatient hospitals	
• Psychiatric inpatient hospitals	
• State-owned non-acute inpatient hospitals operated by the Department of Mental Health (DMH)	
• State-owned non-acute inpatient hospitals operated by the Department of Public Health (DPH)	
• Substance abuse treatment inpatient hospitals	

Present on Admission (POA) indicator:
All inpatient hospital claims related to a PPC must contain the appropriate Present on Admission indicator. If the POA indicator is N or U with respect to a PPC, inpatient hospitals must follow the instructions for billing the PPC below.

POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals		
POA Value on UB-04 or 837I	Description	Payment adjustments
Y	Diagnosis was present at time of inpatient admission.	Payment is made for the condition.
N	Diagnosis was not present at time of inpatient admission.	Applicable PPC payment adjustments will be made.
U	Documentation is insufficient to determine if the	Applicable PPC payment

	condition was present at the time of inpatient admission.	adjustments will be made.
W	Clinically undetermined. The provider was unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition.
Leave field blank	Effective January 1, 2011, the POA field will be left blank for codes exempt from POA reporting. Note: The number “1” is no longer valid on claims submitted under the 5010 format, effective January 1, 2011. Refer to CMS change request 7024 www.cms.gov/transmittals/downloads/R756OTN.pdf	Exempt from POA reporting

Health Care Acquired Conditions (HCACs):
HCACs apply to all providers listed above. Providers must follow the HCAC billing instructions set forth below if an HCAC occurs.

HCACs are conditions occurring in an inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee or total hip replacement in pediatric (under 21 years) and obstetric patients. The table below lists HCACs and their associated ICD-10-CM diagnosis codes.

Note: The HCACs, and associated ICD-10-CM diagnosis codes listed below, are subject to change as a result of revisions to the list of HCACs and related codes made by CMS under Medicare. For the most current list of HCACs and ICD-10-CM diagnosis codes, providers should refer to the CMS Web site at www.cms.gov.

For the list of ICD-10-CM diagnosis and ICD-10-PCS codes associated with the HCACs listed below, click on this link: www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/healthcare-acquired-conditions-icd-10-code-list.html

Health Care Acquired Conditions (HCACs)
Description of condition
Foreign object retained after surgery
Air embolism
Blood incompatibility
Pressure ulcers, stages III & IV
Falls and trauma related to a) fractures b) dislocations c) intracranial injuries d) crushing injuries e) burns f) other injuries
Catheter-associated urinary tract infection (UTI)
Vascular catheter-associated infection
Manifestations of poor glycemic control that include a) diabetes ketoacidosis b) nonketototic hyperosmolar coma c) hypoglycemic coma

d) secondary diabetes with ketoacidosis e) secondary diabetes with hyperosmolarity
Surgical site infection, mediastinitis following coronary artery bypass graft (CABG)
Surgical site infection following certain orthopedic procedures: a) spine b) neck c) shoulder d) elbow
Surgical site infection following bariatric surgery for obesity: a) laparascopic gastric bypass b) gastroenterostomy c) laparoscopic gastric restrictive surgery
Surgical site infection (SS) following Cardiac Implantable Electronic Device (CIED) procedures
Iatrogenic pneumothorax with venous catheterization
Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures: a) total knee replacement b) hip replacement Note: This HCAC category does not apply to pediatric (under 21 years of age) or obstetric patients.

Instructions for Submitting Claims for HCACs

For acute inpatient hospitals, privately owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, psychiatric inpatient hospitals, substance abuse treatment inpatient hospitals, state-owned non-acute inpatient hospitals operated by DMH (UB-04 and 837I institutional claims)

Acute inpatient hospitals:

- ***Acute inpatient hospital APAD, outlier payment, and transfer per diem claims:*** Submit a routine type bill TOB 11X. MMIS will capture the HCAC as indicated on the claim by ICD-10-CM diagnosis and/or ICD-10-PCS code and POA indicator of N or U. Those indicated HCACs will then be excluded from the APR-DRG grouping. See also the "Additional Instructions" in subsection C, below, that provider(s) must follow.
- ***All other acute inpatient hospital claims (rehabilitation services per diem, psychiatric per diem, and administrative day per diem):*** Follow the instructions that apply to all other inpatient hospital provider types, immediately below, for submitting claims for HCACs.

For all other inpatient hospital provider types listed above:

Submit a Type of Bill (TOB) 110 no-pay claim to identify HCAC-related services. HCACs must be identified on the TOB 110 with the appropriate ICD-10-CM diagnosis and ICD-10-PCS codes and a POA indicator (see Table (1)). This TOB 110 must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 110 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an HCAC," and must also state the type of HCAC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-HCAC-related services were also provided during the same statement covers period, submit a second claim to bill for the non-HCAC-related services. The second claim must be billed on a routine type bill TOB 11X (cannot be 110).

See also the "Additional Instructions" below that providers must follow.

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims)

Submit a separate professional claim to identify HCAC-related services. This claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an HCAC," and must also state the type of HCAC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-HCAC-related services were also provided during the same statement covers period, submit a second professional claim to bill for the non-HCAC-related services.

See also the "Additional Instructions" below that providers must follow.

Other Provider Preventable Conditions (OPPCs) by subcategory:

1. National Coverage Determinations (NCDs):
   Applicable providers:
   NCDs apply to all providers listed in above. Providers must follow the NCD billing instructions set forth below if an NCD occurs. See table below for the list of NCDs that may occur in any health care setting.

National Coverage Determinations (NCDs)		
Description of NCD	Diagnosis code	Modifier
Surgical or other invasive procedure performed on the wrong body part	Y65.53 (Performance of correct procedure (operation) on wrong side/body part)	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure performed on the wrong patient	Y65.52 (Performance of procedure (operation) on patient not scheduled for surgery)	PB (Surgical or other invasive procedure on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	Y65.51 (Performance of wrong procedure (operation) on correct patient)	PC (Wrong surgery or other invasive procedure on patient)

Instructions for submitting claims for NCDs:
For acute inpatient hospitals, privately-owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, psychiatric inpatient hospitals, substance abuse treatment inpatient hospitals, state-owned non-acute inpatient hospitals operated by DMH (UB-04 and 837I institutional claims):

Submit a TOB 110 no-pay claim to identify NCD-related services, and include the appropriate POA indicator. NCDs must be identified on the TOB 110 by the applicable diagnosis code reported in positions 2 through 9 (not in the External Cause of Injury (E-code) field). The claim must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD. The claim will deny.

If services unrelated to the NCD were also performed during the same period, submit a second claim to bill for the non-NCD-related services.

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims):

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier to all claim lines related to the erroneous surgery(ies)/ procedure(s). The claim must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD. The claim will deny.

If non-NCD-related services were also provided during the same period, submit a second professional claim to bill for the non-NCD-related services.

2. Additional Other Provider Preventable Conditions (Additional OPPCs):
Applicable Providers:
Additional OPPCs apply to all providers listed above, except for psychiatric inpatient hospitals and state-owned non-acute inpatient hospitals operated by DMH. These providers must follow the billing instructions for Additional OPPCs set forth below, if an Additional OPPC occurs.

   Additional OPPCs may occur in any health care setting and are state-defined other provider preventable conditions that meet the requirements of an "other provider preventable condition" set forth in 42 C.F.R. 447.26(b). The table below lists the MassHealth-defined Additional OPPCs for this purpose:

Additional Other Provider Preventable Conditions (Additional OPPCs)
Description of condition
Intraoperative or immediate postoperative/post-procedure death in an ASA class 1 patient
Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting
Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
Patient death or serious injury associated with patient elopement (disappearance)
Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a health care setting
Patient death or serious injury associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
Death or serious injury of a neonate associated with labor and delivery in a low-risk delivery
Unstageable pressure ulcer acquired after admission/presentation in a healthcare setting
Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting
Death or serious injury of a patient or staff member resulting from a physical assault (that is, battery) that occurs within, or on the grounds of, a health care setting

Instructions for Submitting Claims for Additional OPPCs:

For acute inpatient hospitals, privately-owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, and substance abuse treatment inpatient hospitals (UB-04 and 837I institutional claims):

Submit a TOB 110 no-pay claim type to identify Additional OPPC-related services, and include the appropriate POA indicator. The TOB 110 claim must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC. The claim will deny.

If services unrelated to the Additional OPPC were also provided during the same period, submit a second claim to bill for the non-Additional OPPC-related services. The second claim must be billed on a routine type bill TOB 11X (cannot be 110).

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims):

Submit a separate professional claim to identify Additional OPPC-related services. This claim must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC. The claim will deny.

If services unrelated to the Additional OPPC were also provided during the same period, submit a second professional claim to bill for the non-Additional OPPC-related services.

Additional instructions:

1. Follow-up care:
   Follow the same rules above to report any follow-up inpatient services that were solely the result of a previously reported PPC (inpatient or outpatient) that occurred while a member was being cared for at a facility that is covered under the same license.
2. Related Services for NCDs:
   All services provided in the operating room or other health care setting when an NCD occurs are considered related to the NCD and, therefore, must be reported as NCD-related services in claims submissions in accordance with the instructions for NCDs, above. All providers in an operating room or other health care setting when an NCD occurs, who could bill individually for their services, are not eligible for reimbursement and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.
3. Health Safety Net (HSN)/Unreimbursed Costs:
   Providers cannot seek reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.
4. Prohibition on Charging Members:
   Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.
5. Reporting PPCs to the Department of Public Health:
   The additional instructions apply to the following MassHealth providers.
   - Acute inpatient hospitals.
   - Privately owned chronic disease and rehabilitation inpatient hospitals.
   - State-owned non-acute inpatient hospitals operated by the Department of Public Health.
   - Substance abuse treatment inpatient hospitals.
   - Acute inpatient hospitals billing for acute inpatient hospital-based physician services.

   In addition to complying with the billing instructions set forth above, for any PPC that is also an SRE as designated by the DPH pursuant to its regulations at 105 CMR 130.332, the hospital must continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C). The hospital must also notify the Plan by calling Provider Services at 1-866-275-3247, prompt 4, and provide the Plan with copies of the initial and follow up SRE reports as described in the Plan's *Serious Reportable Events Payment Policy.*

6. SREs that are not PPCs:
   The following events that are designated by the DPH as SREs in accordance with 105 CMR 130.332 (B) and (C) (or 105 CMR 140.308 (B) and (C), as applicable) are not considered PPCs under this policy. These SREs shall be subject to applicable provisions in the Plan's *Serious Reportable Events Payment Policy* for the following providers:

Acute inpatient and acute outpatient hospitals and hospital-licensed health centers (HLHCs)	Acute inpatient and acute outpatient hospitals and HLHCs billing for acute inpatient care and acute outpatient hospital-based physician services
Privately owned chronic disease and rehabilitation inpatient and outpatient hospitals	Freestanding ambulatory surgery centers (FASCs)
State-owned non-acute inpatient and outpatient hospitals operated by the DPH	Substance abuse treatment inpatient and outpatient hospital

   (i) Infant discharged to the wrong person.
   (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
   (iii) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacists, or other licensed health care provider.
   (iv) Abduction of a patient of any age.
   (v) Sexual assault on a patient within or on the grounds of the health-care facility.

Outpatient Hospitals and Freestanding Ambulatory Surgery Centers:
The following instructions apply to outpatient hospital providers (UB-04 or 837I claims); freestanding ambulatory surgery centers (CMS-1500 or 837P claims); and acute outpatient hospital providers billing for acute outpatient hospital-based physician services (CMS-1500 or 837P claims), as indicated below.

Outpatient Hospitals and Freestanding Ambulatory Surgery Centers	
UB-04 or 837I institutional claims	CMS-1500 or 837P professional claims
Acute outpatient hospitals and hospital licensed health centers (HLHCs)	Acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation outpatient hospitals	Freestanding ambulatory surgery centers (FASCs)
Psychiatric outpatient hospitals	
State-owned non-acute outpatient hospitals operated by the Department of Mental Health (DMH) state-owned non-acute outpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment outpatient hospitals	

National Coverage Determinations (NCDs):
NCDs apply to all providers listed above. Providers must follow the NCD billing instructions set forth below if an NCD occurs.

National Coverage Determinations (NCDs)	
Description of NCD	Modifier
Surgical or other invasive procedure performed on the wrong body part	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure	PB (Surgical or other invasive procedure

performed on the wrong patient	on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	PC (Wrong surgery or other invasive procedure on patient)

Instructions for Submitting Claims for NCDs:
For acute outpatient hospitals and HLHCs, privately-owned chronic disease and rehabilitation outpatient hospitals, state-owned non-acute outpatient hospitals operated by DPH, psychiatric outpatient hospitals, substance abuse treatment outpatient hospitals, and state-owned non-acute outpatient hospitals operated by DMH (UB-04 and 837I claims):

Submit a Type of Bill (TOB) 130 no-pay claim type to identify NCD-related services. Append the applicable NCD modifier to all claim lines related to the erroneous surgery(ies)/ procedure(s). This claim must include a separate attachment stating, “This claim represents an NCD,” and must also state the type of NCD. The claim will deny.

If services unrelated to the NCD were also provided during the same period, submit a second claim to bill for the non-NCD-related services. The second claim must be billed on a routine type bill TOB 13X (cannot be 130).

For acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services, and freestanding ambulatory surgery centers (FASCs) (CMS-1500 and 837P claims):

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional claim must include a separate attachment stating, “This claim represents an NCD,” and must also state the type of NCD. The claim will deny.

If non-NCD-related services were also provided during the same period, submit a second professional claim to bill for the non-NCD-related services.

Additional Other Provider Preventable Conditions (Additional OPPCs):
The Additional OPPCs apply to all providers listed above in the table of Outpatient Hospitals and Freestanding Ambulatory Surgery Centers, except for psychiatric outpatient hospitals and state-owned non-acute outpatient hospitals operated by the Department of Mental Health. These providers must follow the billing instructions for Additional OPPCs set forth below if an Additional OPPC occurs.

Additional OPPCs may occur in any health care setting and are state-defined other provider preventable conditions that meet the requirements of an “other provider preventable condition” set forth in 42 C.F.R. 447.26(b). The table below lists the MassHealth-defined Additional OPPCs that apply.

Additional Other Provider Preventable Conditions (Additional OPPCs)
Description of condition
• Intraoperative or immediate postoperative death in an ASA class 1 patient
• Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
• 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
• Patient death or serious disability associated with patient elopement (disappearance)
• Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility
• Patient death or serious disability associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
• Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility

• Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in Neonates
• Patient death or serious disability due to spinal manipulative therapy
• Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility
• Death or significant injury of a patient or staff member resulting from a physical assault (that is, battery) that occurs within, or on the grounds of, a health care facility
In addition, the following five Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:
• Foreign object retained after surgery
• Air embolism
• Blood incompatibility
• Pressure ulcers, stages III & IV
• Falls and trauma related to: a) fractures b) dislocations c) intracranial injuries d) crushing injuries e) burns f) other injuries

Instructions for Submitting Claims for Additional OPPCs:
For acute outpatient hospitals and HLHCs, privately owned chronic disease and rehabilitation outpatient hospitals, state-owned non-acute outpatient hospitals operated by DPH, and substance abuse treatment outpatient hospitals (UB-04 and 837I claims):

Submit a TOB 130 no-pay claim type to identify Additional OPPC-related services. This claim must include a separate attachment stating, “This claim represents an Additional OPPC,” and must also state the type of Additional OPPC. The claim will deny.

If services unrelated to the Additional OPPC were also provided during the period, submit a second claim to bill for the non-Additional OPPC-related services. The second claim must be billed on a routine type bill TOB 13X (cannot be 130).

For acute outpatient hospitals and HLHCs billing for acute outpatient hospital-based physician services, and freestanding ambulatory surgery centers (FASCs) (CMS-1500 and 837P claims):

Submit a separate professional claim to identify Additional OPPC-related services. This claim must include a separate attachment stating, “This claim represents an Additional OPPC,” and must also state the type of Additional OPPC. The claim will deny.

If services unrelated to the Additional OPPC were also provided during the same period, submit a second professional claim to bill for the non-Additional OPPC-related services.

Additional instructions

1. Follow-up Care:
   Follow the same rules above to report any follow-up outpatient services that were solely the result of a previously reported PPC (inpatient or outpatient) that occurred while a member was being cared for at a facility that is covered under the same license.
2. Related Services for NCDs:
   All services provided in the operating room or other health care setting when an NCD occurs are considered related to the NCD and, therefore, must be reported as NCD-related services

in claims submissions in accordance with the instructions for NCDs, above. All providers in an operating room or other health care setting when an NCD occurs, who could bill individually for their services, are not eligible for payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

3. Health Safety Net (HSN)/Unreimbursed Costs:
   Providers are prohibited from seeking reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.
4. Prohibition on Charging Members:
   Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.
5. Reporting PPCs to the Department of Public Health:
   The additional instructions in this paragraph apply to the following MassHealth providers:
   - acute outpatient hospitals
   - privately-owned chronic disease and rehabilitation outpatient hospitals
   - state-owned non-acute outpatient hospitals operated by DPH
   - substance abuse treatment outpatient hospitals
   - acute outpatient hospitals billing for acute outpatient hospital-based physician services
   - freestanding ambulatory surgery centers

   In addition to complying with the billing instructions set forth above, for any PPC that is also a "serious reportable event (SRE)" as designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332 (or 105 CMR 140.308, as applicable), the providers listed above must continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in, and in accordance with, DPH regulations at 105 CMR 130.332 (B) and (C) (or 105 CMR 140.308 (B) and (C), as applicable). The DPH-licensed hospital or FASC must also notify the Plan by calling Provider Services at 1-866-275-3247, prompt 4, and provide the Plan with copies of the initial and follow up SRE reports as described in the Plan's *Serious Reportable Events Payment Policy*.
6. SREs that are not PPCs:
   The following events that are designated by the DPH as SREs in accordance with 105 CMR 130.332 (B) and (C) (or 105 CMR 140.308 (B) and (C), as applicable) are not considered PPCs under this policy. These SREs shall be subject to applicable provisions in the Plan's *Serious Reportable Events Payment Policy* for the following providers:

Acute inpatient and acute outpatient hospitals and hospital-licensed health centers (HLHCs)	Acute inpatient and acute outpatient hospitals and HLHCs billing for acute inpatient care and acute outpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation inpatient and outpatient hospitals	Freestanding ambulatory surgery centers (FASCs)
State-owned non-acute inpatient and outpatient hospitals operated by the DPH	Substance abuse treatment inpatient and outpatient hospital

   (i) Infant discharged to the wrong person
   (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
   (iii) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacists, or other licensed health care provider.
   (iv) Abduction of a patient of any age
   (v) Sexual assault on a patient within or on the grounds of the health-care facility

Billing instructions for all other MassHealth providers:

The following instructions apply to all other providers (providers other than hospitals or freestanding ambulatory surgery centers), whose services include, or who could bill for, “surgical or other invasive procedures” in a health-care setting, as indicated below (CMS-1500 or 837P claims).

CMS-1500 or 837P claims	
Dental providers who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7)	Radiation and oncology treatment centers
Group practice organizations	Independent diagnostic testing facilities (IDTF)
Independent nurse midwives	Freestanding birth centers
Independent nurse practitioners	Family planning agencies
Optometry providers	Sterilization clinics
Physicians	Community health centers
Podiatrists	Abortion clinics

In addition, if any other provider not otherwise listed performs “surgical or other invasive procedures” in a health-care setting (as “surgical or other invasive procedure” is defined by CMS in Medicare guidance for National Coverage Determinations [NCDs]), such provider must comply with the billing instructions set forth below for reporting and billing NCDs.

National Coverage Determinations (NCDs)	
Description of NCD	Modifier
Surgical or other invasive procedure performed on the wrong body part	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure performed on the wrong patient	PB (Surgical or other invasive procedure on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	PC (Wrong surgery or other invasive procedure on patient)

Instructions for Submitting Claims for NCDs:

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier to all claim lines related to the erroneous surgery(ies)/procedure(s). This claim must include a separate attachment stating, “This claim represents an NCD,” and must also state the type of NCD. The claim will deny.

If non-NCD-related services were also provided during the same period, submit a second professional claim to bill for the non-NCD-related services.

Additional instructions

1. Follow-up care:
   Follow the same rules above to report any follow-up services that were solely the result of a previous PPC reported by the provider involving the same member.
2. Related services for NCDs:
   All services provided in the operating room or other health-care setting when an NCD occurs are considered related to the NCD and, therefore, must be reported as NCD-related services in claims submissions in accordance with the instructions above. All providers in an operating room or other health care setting when an NCD occurs who could bill individually for their services are not eligible for payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

Policy history

Origination date: 11/1/2012

Previous revision date(s):	03/01/2013 - Updated list of conditions based on changes made by MassHealth and the Massachusetts Department of Public Health. 07/01/2014 - Reviewed list of conditions for consistency with Massachusetts Department of Public Health. No changes made. 03/01/2016 - Updated billing/coding guidelines to reflect ICD-10 codes and updated to new Plan template.
Connection date & details:	January 2017 – Reviewed list of conditions for consistency with Massachusetts Department of Public Health - updated the CMS list of Hospital Acquired Conditions in this policy accordingly. April 2018 – Annual Review, no updates. April 2019 – Annual Review, no updates. April 2020 – Annual Review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.