EFFECTIVE DATE:03/05/2015
POLICY LAST UPDATED: 01|17/2017

Payment Adjustments for Error and Hospital Acquired Conditions

OVERVIEW

This is an administrative policy that outlines Blue Cross & Blue Shield of Rhode Island (BCBSRI) procedure for handling services that occur as a result of an error, equipment malfunction, or the result of a hospital-acquired condition.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Type of Event

1. Error: No payment is made for services rendered in 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, but is not limited to, 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

2. 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.

3. Hospital-Acquired Conditions (HAC): Diagnosis- Related Group -DRG-based payment methods will follow the most current Medicare payment rules regarding the definitions of HACs 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 POA 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 HACs can be found on the CMS website. See reference section.

Provider Status

Payment adjustments may be to facility payment, professional payment, or both. The HAC adjustments 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 subject to payment adjustment under this policy. 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 contractually allowed. If, as part of risk management or other procedure, a facility elects to forego collection of amounts required by member cost sharing provisions to a greater extent than is required by this policy, the provider will not be considered in violation of contractual agreements.

COVERAGE

Not applicable

BACKGROUND

Value-based payment principles require that there be no payment for services that are performed in error and payment should not be increased to address the costs of complications that are generally preventable.

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 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.

CODING
Not applicable

RELATED POLICIES
Hospital Readmissions

PUBLISHED
Provider Update, March 2017
Provider Update July 2015
Provider Update November 2012

REFERENCES
1. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

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