JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.002
		Effective Date	02/01/2024
		Approval Date	10/25/2023
	Subject **Non-Payment of Preventable Adverse Events (PAE)**	*Supersedes Date*	07/01/2018
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		Page	1 of 6

This document applies to the following Participating Organizations:

Advantage MD	EHP	Priority Partners	US Family Health Plan

Keywords: Healthcare Associated Infections (HAI), Hospital Acquired Conditions (HAC), Never Events, Present On Admission (POA), Preventable Adverse Events (PAE), Provider Preventable Conditions (PPC)

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

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		Page	2 of 6

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

JHHP strives to eliminate patient harm, achieve the best patient outcomes at the lowest possible cost and aligns with CMS to improve the health care quality and patient safety through better reporting of Hospital-Acquired Conditions (HACs), Healthcare Associated Infections (HAIs), Preventable Adverse Events (PAEs), and Provider-Preventable Conditions (PPCs), or "Never Events" (i.e., those conditions or complications that never should have happened), as these errors can occur in almost any health care settings (e.g., hospitals, birthing centers, physician's offices, skilled nursing facilities, pharmacies, urgent care centers, etc.). Federal legislation prohibits payments to certain, non-exempt hospitals, and other facility types in some states, for a complicating condition that could have reasonably been prevented by the provider. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATEMENT

Consistent with CMS guidelines, JHHP follows CMS reimbursement methodology for those conditions or complications that reasonably could have been prevented using evidence-based guidelines and/or considered to be HACs, HAIs, PAEs, PPCs, or "Never Events" that were not present on admission (POA) to the facility and/or that were a result of medical intervention or human error. This policy applies to inpatient and outpatient (as applicable) hospital services, provided to JHHP members. In the State of Maryland, reimbursement for hospital services by all payers classified as Maryland Waiver Hospitals are based upon the rules and rates as established by the Health Services Cost Review Commission (HSCRC) (COMAR 10.09.06.09(A)(1)).

*Providers are responsible for reviewing the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

A. Each line of business possesses its own unique guidelines for benefit and payment purposes, as such JHHP will align with regulatory, state and federal guidance for services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.
B. In addition to facility-related charges, benefits will not provided, where applicable, for charges related to services from the professional provider directly involved in procedures/services that are a result of the HACs, HAIs, PAEs, PPCs, or "Never Events".
C. JHHP members shall be held harmless for any services related to HACs, HAIs, PAEs, PPCs, or "Never Events".
D. Consistent with CMS a Present on Admission (POA) Indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
E. A provider may not knowingly seek reimbursement from a health plan or a patient for any services required to correct or treat problems created by a HACs, HAIs, PAEs, PPCs, or "Never Events" that occurred under the provider's control.
F. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
G. Diagnosis codes are to be used and reported at their highest number of characters available and to the highest level of specificity documented in the medical record.

H. To ensure that billed items or services are covered and are reasonable and necessary, JHHP may pend claims and conduct a review to prevent improper payment to providers.

I. Refer to JHHP's Inpatient Reimbursement Guidelines, policy for additional billing guidance.

V. EXCLUSIONS

1. A. Maryland hospitals are exempt from DRG payment reductions. These hospitals have an agreement with CMS and the state of Maryland.

   B. Those hospitals and hospital unit identified by CMS, are exempt from reporting the POA Indicator and are exempt from HAC/HAI Payment Reductions:

   - Critical access hospitals (CAH)
   - Rehabilitation hospitals and units
   - Long-term care (LTC) hospitals
   - Psychiatric hospitals and units
   - Children's hospitals
   - Prospective Payment System-exempt cancer hospitals
   - Veterans Affairs (VA) hospitals
   - Short-term acute care hospitals located in U.S. territories (Guam, Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa)
   - Religious nonmedical health care institution

VI. EXCEPTIONS

1. A. **PPMCO:** JHHPs aligns with Maryland Medicaid billing and reimbursement methodologies for the claims related to HACs, HAIs, PAEs, PPCs, or "Never Events". Please consult the Maryland Medicaid Provider Manual for additional billing guidance.

   B. **USFHP**: JHHPs aligns with TRICARE billing and reimbursement methodologies for the claims related to HACs, HAIs, PAEs, PPCs, or "Never Events". Refer to the TRICARE Manuals for applicable payment methodologies.

VII. CODES, TERM, DEFINITIONS

Definition of Terms

Term	Definition
Adverse Drug Event (ADE)	Adverse drug events occur after administration of a medication at any dosage level and may or may not incur harm to the patient (e.g., over-dosage of a drug that caused increased monitoring of a patient but no resultant harm).
Adverse Drug Reaction (ADR)	Adverse drug reactions a subset of ADEs in that they only occur following drug administration within normal dose ranges and they result in "noxious and unintended" consequences to the patient.

Adverse Event (AE)	An adverse event is an injury to a patient resulting from a medical intervention, which can be classified as preventable or unpreventable. AEs are a type of injury that most frequently is due to an error in medical or surgical treatment rather than the underlying medical condition of the patient. Adverse events may be *preventable* when there is a failure to follow accepted practice at a system or individual level. • Not all adverse outcomes are the result of an error; hence, only *preventable adverse events* are attributed to medical error. • Adverse events can include unintended injury, prolonged hospitalization, or physical disability that results from medical or surgical patient management. • Adverse events can also include complications resulting from prolonged hospitalization or by factors inherent in the healthcare system.
Diagnosis-Related Group (DRG)	Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG.
Hospital-Acquired Condition (HAC)	A hospital-acquired condition is one of several medical conditions a patient can develop during a hospital stay that was not present on admission (POA), such as a pressure sore or surgical site infection. The Centers for Medicare & Medicaid Services (CMS) has used the HAC designation since October 1, 2008, as required by Section 5001(c) of the Deficit Reduction Act (DRA) of 2005.
Healthcare Associated Infection (HAI)	HAIs, also known as healthcare-associated infections, are nosocomially acquired infections that are not present or incubating at the time of admission to a hospital. These infections are usually acquired after hospitalization.
Inpatient Prospective Payment System (IPPS)	A system of payment for operating costs of acute care hospital inpatient stays based on prospectively set rates. Under IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG.
Medication Errors (ME)	Medication errors are failures in the treatment process that lead to, or have the potential to lead to, harm to the patient.

Never Events	The National Quality Forum (NQF) defines Never Events as errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.
Present On Admission (POA)	POA is defined as present at the time the order for inpatient admission occurs present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA.
Preventable Adverse Drug Reactions (PADR)	Preventable adverse drug reactions include ADRs caused by medication errors, whether they be acts of omission or commission, incorrect medication/dose/timing, and administration of a medication to a patient with a known allergy, inadequate monitoring, or other errors.

Modifiers

Modifier	Definition
PA	Surgery Wrong Body Part
PB	Surgery Wrong Patient
PC	Wrong Surgery/Procedure on Patient

VIII. REFERENCES

This policy has been developed through consideration of the following:

- CMS Hospital-Acquired Conditions
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Medicare Billing Form CMS-1450 and the 837I Booklet
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 3- Inpatient Hospital Billing
- Medicare Claims Processing Manual CH. 25- Completing and Processing the Form CMS-1450 Data Set
- National Uniform Billing Committee (NUBC)
- TRICARE Reimbursement Manual
- TRICARE Reimbursement Manual Chapter 6 Diagnosis Related Groups (DRGs)

IX. REVISION HISTORY

Date	Reveiw/Revision	Reason For Modification	Approved By

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		Page	6 of 6

10/25/2023	Revision	Updated policy language and references. AdvantageMD added to policy.	Reimbursement Policy Committee (RPC)