Payment Policy: Never Paid Events

Reference Number: LA.PP.017
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 08/2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

According to CMS, "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 thus feasible to include in a reporting system), and of a nature such that risk of occurrence is significantly influenced by the policies and procedures of the health care organization."

Louisiana Healthcare Connections will not reimburse for services associated with Never Events. Moreover, providers are not permitted to bill members for never events.

To be included on NQF's list of "never events", an event must be characterized as:

- Unambiguous - clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable - recognizing that some events are not always avoidable, given the complexity of health care;
- Serious - resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- Any of the following:
    - Adverse
    - Indicative of a problem in a health care facility's safety systems
    - Important for public credibility or public accountability

Services and procedures associated with never events include but are not limited to:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Intraoperative or immediately post-operative death in an ASA Class I patient
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare 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 suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy
- 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
- 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
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Application
This policy applies to physicians and hospitals.

Reimbursement
Louisiana Healthcare Connections code auditing software flags all provider claims billed with modifiers -PA, -PB, or -PC. These services deny when billed.
The Health Plan will reimburse physicians for follow up care that is required as a result of a never event only when they are not the physician responsible for the never event.

Utilization
Rationale for Edit
Never events are serious adverse events that in the majority of cases are preventable and should never occur in healthcare. These events are of concern to both the public and healthcare providers. CMS has determined that these events are non-reimbursable. Monitoring these occurrences is intended to encourage hospitals to improve patient safety and to implement standardized protocols.

Documentation Requirements
CMS guidelines require Outpatient, Ambulatory Surgical Centers, and Practitioners to use the following modifiers to identify medical mistakes or errors: PA (Surgery Wrong Body Part), PB (Surgery Wrong Patient) and PC (Wrong Surgery on Patient).

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
-PA	Surgery or Other Invasive Procedure on Wrong Body Part
-PB	Surgery or Other Invasive Procedure on Wrong Patient
-PC	Wrong Surgery or Other Invasive Procedure on Patient

Related Documents or Resources
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Revision History	
08/15/2020	Converted corporate to local policy.

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_

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