Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-195
June 2012

TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: MassHealth Billing Instructions for Provider Preventable Conditions (PPCs); Serious Reportable Events; and Rules about PPCs That Are National Coverage Determinations

This letter transmits the following publications, with all changes effective for dates of service on or after July 1, 2012.

- New Appendix V to all MassHealth provider manuals, which sets forth MassHealth billing instructions that providers must follow for reporting and billing "Provider Preventable Conditions (PPCs)." (See Section I, below.); and
- New Appendix U to all MassHealth provider manuals, which sets forth the list of "Serious Reportable Events (SREs)," designated by the Massachusetts Department of Public Health (DPH), that are not PPCs under MassHealth. (See Section II, below.)

This letter also describes the MassHealth rules governing provider reporting and payment reductions for PPCs that are National Coverage Determinations (NCDs) applicable to providers, whose services include, or who could bill for, "surgical or other invasive procedures" in a health-care setting. (See Section III, below.)

I. MassHealth Billing Instructions for Provider Preventable Conditions (PPCs) – New Appendix V of All MassHealth Provider Manuals

A. Background on Provider Preventable Conditions

(1) 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 PPCs to Medicaid agencies; and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements. MassHealth is implementing policies that conform to the federal requirements on PPCs, effective for dates of service on or after July 1, 2012.

(2) 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 C.F.R. 447.26(b).

(3) 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.

(4) 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 subcategories.

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.

B. Appendix V - Billing Instructions for PPCs

MassHealth is issuing new Appendix V to all MassHealth provider manuals. Appendix V sets forth the MassHealth billing instructions that providers must follow for reporting and billing PPCs, effective for dates of service on or after July 1, 2012. The billing instructions are broken down by applicable providers and PPC categories. Reporting and billing for PPCs in accordance with these instructions is mandatory.

Appendix V is separated in to three parts as described below.

Part 1. PPC Billing Instructions for Inpatient Hospitals
This part contains PPC billing instructions that apply to inpatient hospital providers (UB-04 or 837I claims) and acute inpatient hospital providers billing for acute inpatient hospital-based physician services (CMS-1500 or 837P claims.)

Part 2. PPC Billing Instructions for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers
This part contains PPC billing instructions that 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).

Part 3. PPC Billing Instructions for All Other MassHealth Providers
This part contains PPC billing instructions that apply to all other MassHealth 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 (CMS-1500 or 837P claims).

Appendix V, including the lists of applicable PPCs, may be updated from time to time.

Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals, and their other MassHealth billing and companion guides, as necessary, in billing for PPCs.

C. Payment Adjustments for PPCs

MassHealth rules on payment adjustments for PPCs are set forth (i) in the case of hospital providers, in the hospital's MassHealth agreement governing payment for hospital services and in Section III, below; (ii) in the case of freestanding ambulatory surgery centers (FASCs), in Section III, below, and in Transmittal Letter FAS-25; and (iii) in the case of all other providers, whose services include, or who could bill for, "surgical or other invasive procedures" in a health-care setting, in Section III, below.

D. MassHealth Policy on PPCs That Are Also DPH-Designated SREs

MassHealth hospital and FASC providers licensed by DPH are subject to DPH regulations on Serious Reportable Events (SREs). For all SREs that are also PPCs as identified by MassHealth (that is, those SREs that are **not** listed in Appendix U of all MassHealth provider manuals), DPH-licensed hospital providers and FASC providers must bill for and report these SREs as PPCs in accordance with applicable MassHealth billing instructions in Appendix V, and MassHealth rules governing payment adjustments for PPCs shall apply to these events.

In addition, the DPH-licensed hospital or FASC 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 provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, 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 copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

Instructions to this effect are also included in Appendix V.

II. New Appendix U of All MassHealth Provider Manuals – SREs designated by DPH That Are Not PPCs under MassHealth

As noted above, MassHealth hospital and FASC providers licensed by DPH are subject to DPH regulations about SREs. New Appendix U of all MassHealth provider manuals identifies those events that are designated by DPH as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable), but that are **not** PPCs under MassHealth. For dates of service beginning July 1, 2012, these remaining SREs shall be subject to applicable MassHealth provisions for "Serious Reportable Events" set forth, in the case of DPH-licensed hospital providers, in the hospital's agreement with MassHealth governing payment for services, or in the case of FASCs, in accordance with Transmittal Letter FAS-25.

III. MassHealth Rules Governing Reporting and Payment Reductions for PPCs That Are NCDs

Effective for dates of service on or after July 1, 2012, the following rules governing reporting and payment reductions for PPCs that are NCDs will apply to all providers whose services include, or who could bill for, "surgical or other invasive procedures" in a health-care setting, as the term "surgical or other invasive procedure" is defined by CMS in its Medicare guidance on NCDs. These providers are hospitals (which are subject to Parts 1 and 2 of Appendix V), FASCs (which are subject to Part 2 of Appendix V) and those providers described in Section I of Part 3 of Appendix V.

A. Definitions

For purposes of this Section III, the following definitions apply.

National Coverage Determination (NCD) – means 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; or (iii) surgical or other invasive procedure performed on the wrong patient. The NCDs are a subcategory of the PPC category "Other Provider Preventable Conditions" (OPPCs), as defined in federal regulations at 42 C.F.R. 447.26(b).

Provider Preventable Conditions (PPC) – has the meaning ascribed to such term in federal regulations set forth in 42 CFR 447.26(b).

Surgical or Other Invasive Procedures – has the meaning ascribed to such term by CMS in its Medicare guidance on NCDs.

B. Reporting NCDs to MassHealth

Effective for dates of service on or after July 1, 2012, providers must report the occurrence of an NCD and all NCD-related services through claims submissions to MassHealth. Section C, below, describes services that are considered related to the NCD.

Provider reporting of NCDs, and related claims submissions, must be in accordance with applicable MassHealth regulations, provider manuals, billing instructions, and guidance, as set forth in Appendix V of the provider's MassHealth provider manual.

C. Payment Reductions for NCDs

(1) MassHealth will not pay providers for NCDs that occur when the provider was providing treatment to the member, or that are NCD-related services, that the provider reports through claims submissions. Hospitals should refer to their MassHealth agreement governing payment for hospital services, for additional hospital payment rules 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 not covered. All such services must be reported as NCD-related services in claims submissions in accordance with MassHealth instructions.
- 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 reported 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 covered by MassHealth, and must be reported as NCD-related services.
- Related services do not include performance of the correct procedure.

(2) The MassHealth NCD reporting and non-payment rules also apply to third-party liability and crossover payments by MassHealth.
(3) Providers are prohibited from charging members for NCDs and NCD-related services that are deemed nonpayable by MassHealth, including, without limitation, copayments or deductibles.
(4) 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.
(5) If a provider's future year MassHealth payment rate is calculated using a data source that would otherwise include the NCD, all reported NCD-related costs/services will be excluded from the calculation.
(6) If medically necessary services unrelated to the NCD were provided to the member, MassHealth will cover those services if they are otherwise payable.

D. Reporting NCDs to DPH

In addition to complying with the MassHealth billing instructions and payment rules governing NCDs, MassHealth DPH-licensed hospital providers and FASC providers must continue to report the occurrence of the NCD as a "Serious Reportable Event" 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 provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, 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 copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171.

Effective for dates of service on or after July 1, 2012, claims to MassHealth and related payment methods for NCDs are governed by the applicable MassHealth provisions on NCDs set forth in this Section III. Hospitals should refer to their MassHealth agreement governing payment for hospital services, for additional hospital payment rules for NCDs.

E. MassHealth Requests for Additional Information

MassHealth may request additional information from providers that MassHealth deems necessary to facilitate its review and payment determinations of any NCD and the provider must comply with the request.

IV. Updates to Existing Billing Instructions to Refer Providers to Appendix V for More Information on Billing for PPCs

MassHealth will also be updating the *CMS-1500 Billing Guide*, the *UB-04 Billing Guide*, the *837I Companion Guide*, and the *837P Companion Guide* to refer providers to Appendix V for more information on billing for PPCs.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages 5.7-1 through 5.7-4, U-1, U-2, and V-1 through V-24

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 5.7-1 through 5.7-4 — transmitted by Transmittal Letter ALL-190

Part 7. Other Insurance

This part contains instructions for submitting claims for services provided to members who have other health insurance or Medicare, in addition to MassHealth.

MassHealth regulation at130 CMR 450.316 requires providers to make "diligent efforts" to identify and obtain payment from all other liable parties, including insurers. "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, and include, but are not limited to

- determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider; and
- verifying the member's other health insurance coverage, currently known to MassHealth through EVS, on each date of service and at the time of billing following instructions found in Part 1 of these administrative and billing instructions

For additional information about third-party-liability requirements, see MassHealth regulations at 130 CMR 450.316 through 450.321.

Updating Other Insurance Information

If you have evidence that a member's other health insurance information differs from what appears on EVS, you must fax or mail a Third Party Liability Indicator (TPLI) form to the TPL Unit. To download this form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms and scroll down the list. In addition to the TPLI form, please submit acceptable documentation verifying the coverage change to ensure that the member's file is updated to reflect current information. Acceptable documentation for updating member's insurance information includes an explanation of benefits (EOB), a letter from an employer or health insurance carrier, or a copy of the health insurance card for any new insurance.

Contact information for the TPL Unit is at the bottom of the TPLI form. This information can also be found in Appendix A of your MassHealth provider manual.

Member Has Other Health Insurance

If the member has other insurance, submit the claim to the other insurance carrier, following the other insurer's billing instructions. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, you may submit the claim to MassHealth. You may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the insurer's billing and authorization requirements. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

Coordination of Benefits Claim Submission

837 Transaction

Providers may submit coordination of benefits (COB) claims to MassHealth following instructions found in the HIPAA 837 implementation guides and MassHealth companion guides. Include the other insurer's adjudication information in the transaction as outlined in the guides.

The MassHealth companion guides are available at www.mass.gov/masshealth. To start submitting claims electronically, contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

Provider Online Service Center Direct Data Entry Claim

You can use the Provider Online Service Center (POSC) at www.mass.gov/masshealth/providerservicecenter to submit COB claims to MassHealth using direct data entry (DDE). Job aids are available on the Web to assist providers with COB claim submissions. To download job aids, go to www.mass.gov/masshealth. Click on Information for MassHealth Providers, then on MassHealth Provider Training. Click on NewMMIS Provider Training and choose a job aid from the list.

If you have more questions about DDE claim submission, contact MassHealth Customer Service.

Medicare Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the coordination of benefits contractor (COBC) automatically transmits claims to MassHealth for processing. A claim must contain at least one Medicare-approved service line in order for the entire claim to be automatically crossed over to MassHealth. For Medicare crossover payment methodology, please refer to 130 CMR 450.318.

Providers may submit the claim to MassHealth electronically, following the MassHealth COB requirements if 60 days have passed since you received Medicare payment, or the member has other insurance in addition to Medicare and MassHealth, and the claim has not appeared on a MassHealth crossover remittance advice.

When Medicare Denies Your Entire Claim

When there are no Medicare-approved services on your claim, you may submit a MassHealth claim after you have received an explanation of Medicare benefits (EOMB) indicating that the claim was denied for reasons other than a correctable error. A valid HIPAA adjustment reason code (ARC) from Medicare must be provided with the COB information on your claim.

Adjusting a COB Claim

When the primary insurer (other insurer or Medicare) voids or adjusts a claim that has been previously paid by MassHealth, providers should submit an adjustment claim to MassHealth including the revised COB information on the claim. Refer to MassHealth billing guides for instructions to submit an adjustment claim to MassHealth.

Preventive Pediatric Care and Prenatal Care Services

Preventive pediatric care services may be billed by the provider to MassHealth as primary when the patient has additional insurance (as described in the EPSDT and PPHSD Billing Guidelines for MassHealth Physicians and Mid-level Providers, for members under the age of 21, and prenatal care services including routine prenatal office visits and tests, for members of any age).

Dependent Has Insurance through an Absent Parent

Providers may bill services to MassHealth as the primary insurer if **both** the following conditions are true.

- The dependent has insurance through an absent parent against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue).
- The provider has billed the other insurer and has not received payment or a response for 30 days after billing.

Providers should include the correct carrier code and noncovered amount on their claim submission.

Supplemental Instructions

Please refer to the appendix in your MassHealth provider manual (as listed in the table below) for supplemental instructions that may be applicable to your provider type.

Provider Type	Location
All providers subject to provider preventable conditions	Appendix V of all provider manuals
Acute inpatient hospitals	Appendix D of the *Acute Inpatient Hospital Manual*
Chronic disease and rehabilitation inpatient hospitals	Appendix D of the *Chronic Disease and Rehabilitation Inpatient Hospital Manual*
Community health centers	Appendix D of the *Community Health Center Manual*
Home health agencies	Appendix D of the *Home Health Agency Manual*
Mental health centers	Appendix D of the *Mental Health Center Manual*
Nursing facilities	Appendix G of the *Nursing Facility Manual*
Psychiatric inpatient hospitals	Appendix D of the *Psychiatric Inpatient Hospital Manual*

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DPH-Designated Serious Reportable Events That Are Not Provider Preventable Conditions

Appendix U is applicable to the following MassHealth 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 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 Department of Public Health (DPH)	▪ substance abuse treatment inpatient and outpatient hospital

The following events that are designated by the Massachusetts Department of Public Health (DPH) as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable) are **not** considered "Provider Preventable Conditions" (PPCs) under MassHealth. These SREs shall be subject to applicable MassHealth provisions on "Serious Reportable Events" set forth, in the case of DPH-licensed hospital providers, in the hospital's agreement with MassHealth governing payment for services, or in the case of freestanding ambulatory surgery centers, in Transmittal Letter FAS-25.

1. Infant discharged to the wrong person
2. 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
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
4. Abduction of a patient of any age
5. Sexual assault on a patient within or on the grounds of the health-care facility

NOTE: The above list is subject to change.

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This appendix describes the MassHealth billing instructions for Provider Preventable Conditions (PPCs), as they apply to providers.

This appendix is subdivided into three parts, listed below. This appendix is also available on the MassHealth website at www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Provider Manual Appendices.

Contents

Part 1. Billing Instructions for PPCs for Inpatient Hospitals

I. Applicable Providers

This part contains PPC billing instructions that apply to inpatient hospital providers (UB-04 or 837I claims) and acute inpatient hospital providers billing for acute inpatient hospital-based physician services (CMS-1500 or 837P), as indicated below.

A. UB-04 or 837I institutional claims	*B. 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	

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

II. Provider Preventable Conditions

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, 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.

A Provider Preventable Condition is a condition that meets the definition of a "Health Care Acquired Condition (HCAC)" or an "Other Provider Preventable Condition (OPPC)" as defined by the Centers for Medicare & Medicare Services (CMS) in federal regulations at 42 CFR 447.26(b). "Other Provider Preventable Conditions" are further divided into two subcategories: (1) "National Coverage Determinations (NCDs);" and (2) "Additional Other Provider Preventable Conditions (Additional OPPCs)." See Section III, below, for more information on each of these PPC categories, and for the lists of PPCs that apply to the providers subject to Part 1 of this appendix.

III. Billing Instructions

Set forth below are the MassHealth billing instructions that inpatient hospital providers must follow for reporting and billing PPCs, by applicable PPC subcategory. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals, and their other MassHealth billing and companion guides, as necessary.

Present on Admission (POA) Indicator

All inpatient hospital claims related to a PPC must contain the appropriate Present on Admission (POA) indicator (see Table (1)). If the POA indicator is N or U with respect to a PPC, inpatient hospitals must follow the instructions for billing the PPC below.

Table (1). POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals

POA Value on UB-04 or 837I	Description	Medicaid 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 condition was present at the time of inpatient admission.	Applicable PPC payment 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 Jan 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 Jan. 1, 2011. Refer to CMS change request 7024 www.cms.gov/transmittals/downloads/R756OTN.pdf.	Exempt from POA reporting

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Billing Instructions for Provider Preventable Conditions by PPC Subcategory

A. Health Care Acquired Conditions (HCACs)

Applicable Providers

HCACs apply to all providers listed in Section I, above.[1] 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. Table (2) lists the HCACs and their associated ICD-9-CM diagnosis codes.

Note: The HCACs, and associated ICD-9-CM diagnosis codes listed below, are subject to change as a result of revisions to the list of HACs and related codes made by CMS under Medicare. For the most current list of HACs and ICD-9-CM diagnosis codes, providers should refer to the CMS website at www.cms.gov.

Table (2). Health Care Acquired Conditions (HCACs)

Description of Condition	*ICD-9-CM Diagnosis Codes CC/MCC*
Foreign object retained after surgery	998.4 (CC) 998.7 (CC)
Air embolism	999.1 (MCC)
Blood incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure ulcers, stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and trauma related to a) fractures b) dislocations c) intracranial injuries d) crushing injuries e) burns f) other injuries	Codes with these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994

[1] HCACs under Medicaid rules apply to all inpatient hospitals participating as Medicaid inpatient hospital providers, and are not limited to inpatient hospitals that are subject to the Medicare Inpatient Prospective Payment System.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Description of Condition	*ICD-9-CM Diagnosis Codes CC/MCC*
Catheter-associated urinary tract infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular catheter-associated infection	999.31 (CC)
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	250.10 - 250.13 (MCC) 250.20 - 250.23 (MCC) 251.0 (CC) 249.10 - 249.11 (MCC) 249.20 - 249.21 (MCC)
Surgical site infection, mediastinitis following coronary artery bypass graft (CABG)	519.2 (MCC) and one of following procedure codes 36.10 - 36.19
Surgical site infection following certain orthopedic procedures: a) spine b) neck c) shoulder d) elbow	996.67 (CC) 998.59 (CC) and one of the following procedure codes: 81.01 - 81.08, 81.23 - 81.24, 81.31 -81.38, 81.83, or 81.85
Surgical site infection following bariatric surgery for obesity: a) laparascopic gastric bypass b) gastroenterostomy c) laparoscopic gastric restrictive surgery	Principal diagnosis code 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
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.	415.11 (MCC) 415.13 (MCC) 415.19 (MCC) 453.40 - 453.42 (CC) and one of the following procedure codes: 00.85 - 00.87, 81.51 - 81.52, or 81.54

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

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)

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-9-CM diagnosis codes (see Table (2)) 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" in subsection C, 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**"** in subsection C, below, that providers must follow.

B. Other Provider Preventable Conditions (OPPCs) by Subcategory

(1) National Coverage Determinations (NCDs)

Applicable Providers

NCDs apply to all providers listed in Section I above. Providers must follow the NCD billing instructions set forth below if an NCD occurs. See Table (3) for the list of NCDs that may occur in any health care setting.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Table (3). National Coverage Determinations (NCDs)

Description of NCD	*Diagnosis Code*	*Modifier*
Surgical or other invasive procedure performed on the wrong body part	E876.7 (Performance of wrong operation (procedure) 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	E876.6 (Performance of operation (procedure) 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	E876.5 (Performance of wrong operation (procedure) 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 (see Table (1)). NCDs must be identified on the TOB 110 by the applicable diagnosis code from Table (3), above, reported in positions 2 through 9 (not in the External Cause of Injury (E-code) field). 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 NCD," and must also state the type of NCD (from Table (3)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the NCD were also performed during the same statement covers 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 11X (cannot be 110).

See also the "Additional Instructions**"** in subsection C, 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 NCD-related services. Append the applicable NCD modifier (from Table (3)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional 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,

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

"This claim represents an NCD," and must also state the type of NCD (from Table (3)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

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

See also the "Additional Instructions" in subsection C below, that providers must follow.

(2) Additional Other Provider Preventable Conditions (Additional OPPCs)

Applicable Providers

Additional OPPCs apply to all providers listed in Section I, 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 CFR 447.26(b). Table (4) lists the MassHealth-defined Additional OPPCs for this purpose.

Table (4). 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

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Description of Condition
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

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 (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 Additional OPPC," and must also state the type of Additional OPPC (from Table (4)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers 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).

See also the "Additional Instructions" in subsection C, 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 Additional OPPC-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 Additional OPPC," and must also state the type of Additional OPPC (from Table (4)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

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

See also the "Additional Instructions" in subsection C, below, that providers must follow.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

C. 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 payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

(3) Providers Approved for an Electronic Submission Waiver

If a provider has been approved for an electronic submission waiver, the provider may submit a separate UB-04 or CMS-1500 claim, as applicable, on paper for the PPC. Providers must include the appropriate diagnosis codes or modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable PPC, and must include a separate attachment with the paper claim stating, "This claim represents an [HCAC][NCD][Additional OPPC]," and must also state the type of PPC (from the appropriate table, above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

(4) 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.

(5) Prohibition on Charging Members

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(6) Reporting PPCs to the Department of Public Health

The additional instructions in this paragraph 6 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

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

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, 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 provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C). The copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

(7) Serious Reportable Events

For all providers listed in Paragraph 6 of these Additional Instructions, above, Appendix U of all provider manuals identifies those events that are designated by DPH as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332, but which are **not** "provider preventable conditions" under MassHealth. The SREs listed in Appendix U are governed by applicable provisions on "Serious Reportable Events" set forth in the provider's MassHealth agreement governing payment for hospital services, including, without limitation, provisions concerning nonpayment and reporting for these events.

(8) Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance

Providers must follow the instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing guide and companion guides to submit COB claims as necessary.

(a) **HCACs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

No further action is required for Medicare crossover claims that are submitted by inpatient provider types listed in Section I, above, that are also subject to Medicare's Inpatient Prospective Payment System (IPPS) rules.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Inpatient provider types listed in Section I, above, that are **not** subject to Medicare's IPPS rules must re-bill their crossover claims to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(b) **NCDs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

No further action is required for Medicare crossover claims that are automatically transmitted from Medicare to MassHealth for adjudication.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(c) **Additional OPPCs**

Third Party Liability

If there is a remaining MassHealth liability, submit claim to MassHealth according to the MassHealth Additional OPPC requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

Medicare crossover claims billed for Additional OPPCs listed in Table (4) must be rebilled to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers

I. Applicable Providers

This part contains PPC billing instructions that 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.

A. UB-04 or 837I institutional claims	B. 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	

II. Provider Preventable Conditions

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, 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.

A Provider Preventable Condition, for purposes of the providers listed in Section I, above, includes conditions that meet the definition of an "Other Provider Preventable Condition (OPPC)" as defined by CMS in federal regulations at 42 CFR 447.26(b). "Other Provider Preventable Conditions" are further divided into two subcategories: (1) "National Coverage Determinations (NCDs);" and (2) "Additional Other Provider Preventable Conditions (Additional OPPCs)." See Section III, below, for more information on each of these PPC categories, and for the lists of PPCs that apply to the providers subject to this Part 2.

III. Billing Instructions

Set forth below are the MassHealth billing instructions that providers must follow for reporting and billing PPCs, by applicable PPC subcategory. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals, and their other applicable MassHealth billing and companion guides, as necessary.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

A. National Coverage Determinations (NCDs)

Applicable Providers

NCDs apply to all providers listed in Section I, above. Providers must follow the NCD billing instructions set forth below if an NCD occurs. See Table (1) for the list of NCDs, which may occur in any health care setting.

Table (1). 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

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 (from Table (1)) to all claim lines related to the erroneous surgery(ies)/ procedure(s). This TOB 130 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 TOB 130 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the NCD were also provided during the same statement covers 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).

See also the "Additional Instructions" in subsection C, below, that providers must follow.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

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 (from Table (1)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional 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 NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

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

See also the "Additional Instructions" in subsection C, below, that providers must follow.

B. Additional Other Provider Preventable Conditions (Additional OPPCs)

Applicable Providers

The Additional OPPCs apply to all providers listed in Section I, above, 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 CFR 447.26(b). Table (2) lists the MassHealth-defined Additional OPPCs that apply to the providers listed in Section I, above.

Table (2). 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

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Description of Condition
▪ 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 six 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
▪ 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

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

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 TOB 130 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 TOB 130 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers 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).

See also the "Additional Instructions" in subsection C, below, that providers must follow.

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 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 Additional OPPC," and must also state the type of Additional OPPC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

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

See also the "Additional Instructions" in subsection C, below, that providers must follow.

C. 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.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

(3) Providers Approved For An Electronic Submission Waiver

If a provider has been approved for an electronic submission waiver, the provider may submit a separate UB-04 or CMS-1500 claim, as applicable, on paper for the PPC. Providers must include the appropriate diagnosis codes or modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable PPC, and must include a separate attachment with the paper claim stating, "This claim represents an [NCD][Additional OPPC]," and must also state the type of PPC (from the appropriate table, above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

(4) 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.

(5) Prohibition on Charging Members

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(6) 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 ouptatient 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). These MassHealth providers must also provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, 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 copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

(7) Serious Reportable Events

For MassHealth providers listed in paragraph 6 of these Additional Instructions, above, Appendix U of all provider manuals identifies those events that are designated by DPH as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable), but which are not "provider preventable conditions" under MassHealth. The SREs listed in Appendix U are governed by applicable provisions on "Serious Reportable Events," including, without limitation, provisions concerning nonpayment and reporting for these events set forth, in the case of hospital providers, in the provider's MassHealth agreement governing payment for hospital services, or in the case of freestanding ambulatory surgery centers, in Transmittal Letter FAS-25.

(8) Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance

Providers must follow instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing and companion guides to submit COB claims as necessary.

(a) **NCDs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication. No further action is required for Medicare crossover claims.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(b) **Additional OPPCs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth Additional OPPC requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare Crossover claims for dually eligible members to MassHealth for adjudication.

Medicare crossover claims billed for Additional OPPCs listed in Table (2) must be rebilled to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers

I. Applicable Providers

This part contains PPC billing instructions that apply to all other MassHealth 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 MassHealth provider not otherwise listed in Section I of Parts 1, 2, or 3 of Appendix V perform "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.

II. Provider Preventable Conditions (PPCs)

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, 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.

For purposes of the providers listed in Section I, above, PPCs refer to "Other Provider Preventable Conditions" that are the three National Coverage Determinations (NCDs), which may occur in any health care setting. See Table (1), below for the list of NCDs.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

Table (1). 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)

III. Billing Instructions

Set forth below are the MassHealth billing instructions that providers must follow for reporting and billing NCDs. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals and their other applicable MassHealth billing and companion guides, as necessary.

Applicable Providers
These instructions apply to all providers described in Section I, above.

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier (from Table (1)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional 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" section below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

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

IV. Additional Instructions

(A) **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.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

(B) **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.

(C) **Providers Approved for an Electronic Submission Waiver**

If a provider has been approved for an electronic submission waiver, the provider may submit a separate CMS-1500 claim on paper for the NCD. Providers must append the appropriate modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable NCD and NCD-related services, and must include a separate attachment with the paper claim stating,"This claim represents an NCD," and must also state the type of NCD (from Table (1), above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

(D) **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.

(E) **Prohibition on Charging Members**

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(F) **Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance**

Providers must follow instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing and companion guides to submit COB claims as necessary.

NCDs

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

No further action is required for Medicare Crossover claims that are submitted by applicable provider types listed in Section I, above.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described in Section III, above. Providers must report Medicare's COB information on their MassHealth claim submission.

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