Priority Health	BILLING POLICY No. 172

MEDICAL ERRORS: SERIOUS REPORTABLE EVENTS/ HOSPITAL ACQUIRED CONDITIONS

Date of origin: December 2025	Review dates: 9/2026

POLICY OVERVIEW

This policy outlines proper reporting for Hospital Acquired Conditions (HAC) and events that are preventable and occur while in a facility that requires reporting. Patients and payers are not financially responsible for Provider Preventable Conditions (PPCs).

DEFINITIONS

Serious Reportable Events (SRE) – These are events that should never happen in a healthcare setting

- Hospital Acquired Conditions (HAC) – Conditions that develop during a hospital stay
- Present on Admission (POA) indicator – A code used to indicate if a diagnosis was present at the time of an inpatient admission.
- Never Events – A term previously used by the National Quality Forum for 28 preventable occurrences in healthcare.
- Adjustment factor- A ratio used to adjust payment based on DRG when conditions were not present on admission

MEDICAL POLICY

N/A

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

Provider Preventable Conditions (PPCs) are classified into two separate categories:

- **Health Care-Acquired Conditions (HCACs):** Occur in inpatient hospital settings and include conditions such as foreign objects retained after surgery, air embolism, blood incompatibility, stage III/IV pressure ulcers, falls and trauma, catheter-associated urinary tract infections, vascular catheter-associated infections, manifestations of poor glycemic control, and surgical site infections following specific procedures like CABG, bariatric, or orthopedic surgeries. They can be identified by the Present on Admission (POA) indicator. This field is mandatory for inpatient claims.

Indicator	Description
Y	Diagnosis was present at the time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	cumentation is insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04

- **Other Provider-Preventable Conditions (OPPCs):** Occur in any health care setting and include wrong surgical procedures, surgery on the wrong body part, or surgery on the wrong patient, as well as other state-identified conditions. A non-covered claim with Bill Type 0110 must contain one of the following diagnosis codes:

ICD-10	Description
Y65.51	Performance of wrong procedure (operation) on correct patient
Y65.52	Performance of operation (procedure) on patient not scheduled for surgery
Y65.53	Performance of correct operation (procedure) on wrong side/body part

- The applicable HCPCS modifier must be appended to all claim lines related to the incorrect surgery:

Modifier	Description
PA	Surgery Wrong Body Part
PB	Surgery Wrong Patient
PC	Surgery Wrong Patient

Place of service

This policy is applicable in any recognized healthcare setting including hospitals, surgical centers, non-acute care facilities, physicians' offices, infusion centers, and the home.

Documentation requirements

Acute care inpatient facilities must report hospital acquired conditions to priority health within 48 hours.

Priority health tracks serious reportable events and HACs through case management, claims review, and member complaints.

Ways to report:
Phone:

- Customer Service: (800) 942-0954
- Provider Helpline: (800) 942-4765
- RN Care Manager (Quality Concerns): (616) 355-3234

Email**:** QCC@PriorityHealth.com

Effective October 1, 2015, the ICD-10 Version 33 Hospital Acquired Condition (HAC) list replaced the ICD-9-CM Version 32 HAC list.. See list below:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

FAQ

- The purpose of this policy is to monitor avoidable risks to patients by addressing SREs and hospital acquired payment is withheld for medical errors.
- Acute care inpatient facilities must report HACs to Priority Health within 48 hours of the event.

- Priority Health monitors SREs/ HACs through case management, member complaints and claims review.
- Priority Health investigates cases under the management of clinical and confidential concerns of policy.
- No payment will be made for medical errors
- Providers may appeal payment decisions

Resources

- CMS Improves Patient Safety for Medicare and Medicaid by Addressing Never Events https://www.cms.gov/newsroom/fact-sheets/cms-improvespatient-safety-medicare-and-medicaid-addressing-never-events
- CMS Hospital Acquired Conditions @ https://www.cms.gov/medicare/payment/fee-for-serviceproviders/hospital-aquired-conditionshac?redirect=/HospitalAcqCond/03_AffectedHospitals.asp#TopOfP age (Retrieved September 26, 2024) (Appendix 2)
- National Quality Forum (NQF), Serious Reportable Events In Healthcare—2011 Update: A Consensus Report, Washington, DC: NQF; 2011
- National Quality Forum List of SREs @ http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx (Retrieved August 3, 2023) (Appendix 1)

Related policies

- The HAC & POA web page at http://www.cms.hhs.gov/HospitalAcqCond/ provides further information, including links to the law, regulations, change requests (CRs), and educational resources, including presentations, MLN articles, and fact sheets.
- Appendix 1 – List of Serious Reportable Events source: National Quality Forum website, accessed 10/8/2014, 9/30/2015, 10/11/2016 & 10/17/2017, 10/2/2019, 9/14/2020, 9/1/2021, 8/31/2022, 9/14/2023
- http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx
- ICD-10 HAC List | CMS

Related denial language

Priority Health reserves the right to deny payment for all, or part of services rendered when an SRE or HAC occurs during the inpatient stay. Claims associated with medical errors will not be reimbursed.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to the procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

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

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
12/17/25	Policy created
9/26	Changed the current Definitions to Policy Overview, rearranged Coding specifics, and added CPT codes and a Modifier table.