Hospital Acquired Conditions and Never Events

Policy Admin-014

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.

Description:

Hospital Acquired Condition (HAC) are conditions not present when a patient is admitted or arrives at the hospital or other facility, but occurs during or after the stay and are usually preventable. HACs include conditions such as decubitus ulcers, urinary tract infections due to urinary catheters, surgical site infections, etc. as the list of HACs published and updated by the Center for Medicare and Medicaid Studies (CMS) in the Inpatient Prospective Payment System Final Rule. The HACs include iatrogenic complications caused by providers or other health care personnel including but not limited to air embolism, blood incompatibility, misplaced instruments, wrong side surgery or other such events, and serious reportable events (SRE). SREs are also known as "Never Events". These are events considered preventable and usually result in serious harm to the patient.

University of Utah Health Plans reviews claims for Hospital Acquired Conditions (HACs), Never Events, and Iatrogenic Complications. This policy outlines the review process and coverage for these conditions.

Policy Statement and Criteria

1. **Commercial Plans**

   University of Utah Health Plans does NOT cover direct costs associated with Hospital Acquired Conditions (as defined by CMS), Never Events or Iatrogenic Complications.

   Those direct costs identified to be related to hospital acquired conditions, never events or iatrogenic complications will be removed from any DRG or other payments due to providers with appropriate recalculation of payment for otherwise identified medically necessary covered services based on these considerations.

A. The current 14 CMS categories of HACs include:

    i. Foreign Object Retained After Surgery

    ii. Air Embolism

    iii. Blood Incompatibility

    iv. Stage III and IV Pressure Ulcers

    v. Falls and Trauma:

        a. Fractures

        b. Dislocations

        c. Intracranial Injuries

        d. Crushing Injuries

        e. Burn

        f. Other Injuries

    vi. Manifestations of Poor Glycemic Control:

        a. Diabetic Ketoacidosis

        b. Nonketotic Hyperosmolar Coma

        c. Hypoglycemic Coma

        d. Secondary Diabetes with Ketoacidosis

        e. Secondary Diabetes with Hyperosmolarity

    vii. Catheter-Associated Urinary Tract Infection (UTI)

    viii. Vascular Catheter-Associated Infection

    ix. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)

    x. Surgical Site Infection Following Bariatric Surgery for Obesity:

        a. Laparoscopic Gastric Bypass

        b. Gastroenterostomy

        c. Laparoscopic Gastric Restrictive Surgery

    xi. Surgical Site Infection Following Certain Orthopedic Procedures:

        a. Spine

        b. Neck

        c. Shoulder

        d. Elbow

    xii. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

xiii. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain

xiv. Orthopedic Procedures:

    a. Total Knee Replacement

    b. Hip Replacement

xv. Iatrogenic Pneumothorax with Venous Catheterization

2. **Medicaid Plans**

Healthy U is contractually obligated to NOT pay a provider for provider-preventable conditions, as identified in the State plan.

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

3. **Medicare Plans**

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicare policies and coverage, please visit their search website at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

Clinical Rationale

The term "Never Event" was first introduced in 2001 by Ken Kizer, MD, former CEO of the National Quality Forum (NQF), in reference to particularly shocking medical errors—such as wrong-site surgery—that should never occur. Over time, the term's use has expanded to signify adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable. Since the initial never event list was developed in 2002, it has been revised multiple times, and now consists of 29 "serious reportable events" grouped into 7 categories:

- Surgical or procedural events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Criminal events

Most Never Events are very rare. For example, a 2006 study estimated that a typical hospital might experience a case of wrong-site surgery once every 5 to 10 years. However, when Never Events occur, they are devastating to patients–71% of events reported to the Joint Commission over the past 12 years were fatal–and may indicate a fundamental safety problem within an organization. Although individual events are uncommon, on a population basis, many patients still experience these serious errors. A 2013 study estimated that more than 4000 surgical never events occur yearly in the United States.

The Joint Commission has recommended that hospitals report "sentinel events" since 1995. Sentinel events are defined as "an unexpected occurrence involving death or serious physiological or psychological injury, or the risk thereof." The NQF's Never Events are also considered sentinel events by the Joint Commission. The Joint Commission mandates performance of a root cause analysis after a sentinel event. The Leapfrog Group recommends that in addition to an RCA, organizations should disclose the error and apologize to the patient, report the event, and waive all costs associated with the event.

Because Never Events are devastating and preventable, health care organizations are under increasing pressure to eliminate them completely. The Centers for Medicare and Medicaid Services (CMS) announced in August 2007 that Medicare would no longer pay for additional costs associated with many preventable errors, including those considered Never Events. Since then, many states and private insurers have adopted similar policies. Since February 2009, CMS has not paid for any costs associated with wrong-site surgeries.

Never Events are also being publicly reported, with the goal of increasing accountability and improving the quality of care. Since the NQF disseminated its original Never Events list in 2002, 11 states have mandated reporting of these incidents whenever they occur, and an additional 16 states mandate reporting of serious adverse events (including many of the NQF Never Events). Health care facilities are accountable for correcting systematic problems that contributed to the event, with some states (such as Minnesota) mandating performance of a root cause analysis and reporting its results.

The most recently available list of Never Events are listed in the following table:

National Quality Forum List of Serious Reportable Events, 2016
Surgical events
• Surgery or other invasive procedure performed on the wrong body part
• Surgery or other invasive procedure performed on the wrong patient
• Wrong surgical or other invasive procedure performed on a patient
• Unintended retention of a foreign object in a patient after surgery or other procedure
• Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class I patient
Product or device events
• Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting

- Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended

- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting

Patient protection events

- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person

- Patient death or serious disability associated with patient elopement (disappearance)

- Patient suicide, attempted suicide, or self-harm resulting in serious disability, while being cared for in a health care facility

Care management events

- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)

- Patient death or serious injury associated with unsafe administration of blood products

- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting

- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

- Artificial insemination with the wrong donor sperm or wrong egg

- Patient death or serious injury associated with a fall while being cared for in a health care setting

- Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a health care facility

- Patient death or serious disability resulting from the irretrievable loss of an irreplaceable biological specimen

- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

Environmental events

- Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a health care setting

- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances

- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting

- Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a health care setting

Radiologic events
• Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area
Criminal events
• Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
• Abduction of a patient/resident of any age
• Sexual abuse/assault on a patient within or on the grounds of a health care setting
• Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

Applicable Coding

CPT Codes

Too many codes to list.

HCPCS Codes

Too many codes to list.

References:

1. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2006-Fact-Sheets-Items/2006-05-18.html
2. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html
3. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html; last accessed 8/15/19
4. http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx
5. Utah Administrative Code R414-2A-8. Provider-Preventable Conditions.
6. Utah Medicaid Provider Manual, Hospital Services, updated January 2019; Section 9-14; last accessed 9/1/19