Never Events-Serious Avoidable Events

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

In 2002, the National Quality Forum developed quality standards that measure and encourage reporting 27 serious, largely preventable conditions that should never happen to a hospital patient. The list continues to evolve and includes preventable errors arising from surgery, medical devices or products; inadequate patient protection; inadequate care management; unclean or unsafe environmental conditions; or criminal acts.

This list does not capture all events that might possibly be useful to report. Rather, the items on the list are events that are of concern to both the public and healthcare professionals and providers; clearly identifiable and measureable; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization.

The intent was to create national consensus around a common set of adverse events which needed to be investigated, analyzed for root cause and reported any time they occur. These events soon became known as "Never Events" (those that should never happen) or Serious Avoidable Events (those that could be prevented by following evidence-based guidelines).

On October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) Medicare enacted its policy to not pay the extra costs attributable to preventable illnesses and injuries suffered in a hospital. Other health plan carriers soon followed with related guidelines. In 2009, with the passage of Oregon HB 2009 and HB 2116, the Oregon Health Policy Board and the Oregon Health Authority were created. One of their quality initiatives included partnering with the Oregon Patient Safety Commission, a state agency created to improve patient safety by reducing the risk of Serious Adverse Events and improving patient outcomes.

Both the Oregon Public Employees' and Educators' Benefit Boards health plan contracts require that plans cease paying hospitals for "Never Events" as defined by CMS Medicare.

Also included in this policy are Serious Avoidable Events. Serious Avoidable Events are medical errors that result in additional procedures, increased level of care, and/or increased length of stay. Serious

Avoidable Events are prevented by the application of established practices and evidence-based guidelines. These events are also called Hospital Acquired Conditions (HAC), and are monitored using the “Present On Admission (POA)” indicator.

Any potential Never Event or Serious Avoidable Event needs to be reported to the Quality Department for tracking and determination of whether it is a reportable event.

In addition, Pacificsource utilizes the following processes to identify Never Events or Serious Avoidable Events:

- **Claims Procedures**. Includes the identification of specific diagnostic codes that may indicate an adverse occurrence, and oversight of the POA (present on admission) codes submitted on claims.
- **Concurrent reviews**. Includes the review of all hospitalized members. If a potential Never Event or Serious Avoidable Event is identified, a full clinical review of the occurrence is conducted. If warranted, claims payment may be reduced in accordance with the specific event under review and in accordance with this guideline.

Criteria

Commercial

Reimbursement Policy

Per this policy reimbursement is not provided for “Never Events”, “Serious Avoidable Events”, nor any service directly related to the “Never Event” as defined below. This would include all facility, ancillary, and/or professional services billed. Additionally, reimbursement is not available for Serious Avoidable Events (also termed hospital acquired conditions) as these events could reasonably have been prevented through the application of evidence-based guidelines.

For a list that includes, but is not limited to Never Event or Serious Avoidable Event examples, see the table in the definition section.

Participating providers will not seek payment from the insurer, or its members for additional charges directly resulting from the occurrence of such events if one or more of the following happen:

- The event results in an increased length of stay, level of care, or significant intervention;
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service;
- An unintended procedure is performed; and/or
- Readmission is required as a result of an adverse event that occurred in the same facility.

This reimbursement guideline applies only to the care made necessary by the Serious Avoidable or Never Event.

In order to identify and monitor avoidable hospital conditions, the inclusion of the appropriate ICD-10 CM code and the Present on Admission (POA) indicator are required on claims submission (field 67 of the UB-04).

The POA codes are:

Y = Present at the time of inpatient admission

N = Not present at the time of inpatient admission

U = Documentation is insufficient to determine if condition is present on admission

W = Provider is unable to clinically determine whether condition was present on admission or not

1 = Exempt from POA reporting.

Medicaid

PacificSource Community Solutions follows Oregon Administrative Rules (OAR) 410-125-0450(2)(b) for Never Events-Serious Avoidable Events.

Medicare

PacificSource Medicare follows the Never Events-Serious Avoidable Events under the Deficit Reduction Act (DRA), section 5001 (c) and the current HAC list.

Definitions

Never Events/Serious Avoidable Events - significant and costly health care errors that should never happen. These events cause serious injury or death and often result in increased health care costs to treat the consequences of the error. To be classified as a Never Event, the error in medical care must:

- Be clearly identifiable;
- Be usually preventable when evidence-based practices are followed;
- Have serious consequences for the patient (e.g., resulting in death, loss of a body part, disability, or more than transient loss of a body function); and
- Indicate real problems in the safety and credibility of a health care facility.

Serious Avoidable Events (also known as Hospital Acquired Conditions) - events that could reasonably have been prevented through the use of evidence-based guidelines. These conditions are not present when the patient is admitted to a facility, but present during the course of the stay.

The following instances reflect those events that would be classified as Never Events or Serious Avoidable Events specific to provider reimbursement: This is not an all-inclusive list.

Surgical Event	Additional Specifications
Surgery performed on the wrong body part	Includes surgery on the right body part but in the wrong location (e.g. level of spine) Surgeries include endoscopies and other invasive procedure Medical necessity for the procedure performed and/or member informed consent not documented Excludes emergency procedures that occur during the course of surgery (e.g. repair of lacerated blood vessel)

	Excludes discovery of pathology in close proximity to the intended site when the risk of second surgery outweighs the need to address
Surgery performed on wrong patient	Surgeries include endoscopies and other invasive procedure No documentation of informed consent to perform procedure
Wrong surgical procedure on a patient	Surgeries include endoscopies and other invasive procedure Patient did not sign informed consent for procedure performed Excludes emergent situations that occur in the course of surgery and/or need to address outweighs obtaining informed consent
Unintended retention of a foreign object in a patient after surgery or other procedure	Excludes: • Objects present prior to surgery that are intentionally left in place • Objects intentionally implanted as part of a planned intervention • Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention (e.g. microneedles, broken screws)
Intraoperative or immediately post-operative death in an otherwise healthy patient (ASA class I)	ASA Class I patient death in cases where anesthesia was administered Immediately post-operative means within 24 hours after surgery or procedure completed or after anesthesia if surgery was stopped before completion
Product or Device Event	**Additional Specifications**
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologicals provided by the healthcare facility	Includes detectable contaminants in drugs, devices, or biologicals regardless of the source of the contamination and/or product
Patient death or serious disability associated with the use or function of a	Includes, but not limited to, infusion pumps, ventilators, drains or other tubes, catheters

device in patient care in which the device is used or functions other than as intended	
Patient death or serious disability associated with intravascular air embolism that occurs while being care for in a healthcare facility	Excludes death or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism
Case Management Events	**Additional Specifications**
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood product	
Patient death or serious disability 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	Includes administration of medication to patient with known allergy Includes drug-drug interactions that have a potential for death or serious disability
Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility	Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	
Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.	Hyperbilirubinemia defined as bilirubin level > 30 mg/dl Neonates include infants to first 28 days of life
Stage 3 or 4 pressure ulcer acquired after admission to a healthcare facility	Excludes progression from Stage 2 to Stage 3, if Stage 2 was recognized on admission
Patient death or serious disability due to spinal manipulative therapy	
Environmental Events	**Additional Specifications**
Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	Excludes events involving planned treatments such as electric counter shock or elective cardioversion

Incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	
Patient death or serious disability associated with a fall while being cared for in a healthcare facility	Includes, but not limited to, fractures, head injuries, intracranial hemorrhage
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.	
Criminal Acts	**Additional Specifications**
Care ordered or provided by a person impersonating a healthcare provider.	
Abduction of a patient	
Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.	

References

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Appendix

Policy Number:

Effective: 2/1/2020 **Next review:** 6/1/2022

Policy type: Enterprise

Author(s):

Depts: Health Services, Provider Network

Applicable regulation(s):

Commercial Ops: 5/2021

Government Ops: 5/2021