Never Events-Serious Avoidable Events

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

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 determinations 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

The National Quality Forum developed quality standards in 2002 that measure and encourage the reporting of 27 serious, largely preventable conditions (e.g., Never Events) that should never happen to a hospital patient. The list continues to evolve and includes the following:

- Preventable errors arising from surgery, medical devices, or products;
- Inadequate patient protection;
- Inadequate care management;
- Unclean or unsafe environmental conditions;
- 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 measurable; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization.

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

PacificSource Quality Department requires any potential Never Event, SAE, or HAC to be reported, tracked, and determined if it is a reportable event and/or if it is a reimbursable event. Never Events,

SAEs, or HACs can come in any door of PacificSource (i.e., member complaint); however, the two following processes are the two most common utilized to identify Never Events or SAEs:

- **Claims Procedures**. Includes the identification of specific diagnostic codes that may indicate an adverse occurrence, and oversight of the POA codes submitted on claims.
- **Concurrent reviews**. Includes the review of all hospitalized members. If a potential Never Event or SAE 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

I. Reimbursement of Never Events, Serious Avoidable Events (SAEs), or Hospital Acquired Conditions (HACs)

PacificSource does not provide reimbursement for "Never Events," nor any service directly related to the "Never Event." This would include all facility, ancillary, and/or professional services billed. Additionally, reimbursement is not available for Serious Avoidable Events (SAEs) or Hospital Acquired Conditions (HACs) as these events could reasonably have been prevented through the application of evidence-based guidelines.

A. Never Events

Never Events, include, but are not limited to the following (for a comprehensive list, visit the National Quality Forum website):

- Surgical Events
  - Surgery or other invasive procedure performed on the wrong site, wrong patient, etc.
  - Wrong surgical or other invasive procedure performed on a patient
  - Unintended retention of a foreign object in a patient after surgery or other invasive procedure
  - Intraoperative or immediately postoperative/post-procedure death in an ASA Class I patient
- Product or Device Events
  - Patient death or serious injury associated with the use of contaminated drugs, devices, or biologicals provided by the healthcare facility
  - Patient death or serious injury 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 injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- Environmental Events
  - Patient death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting

    - An incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
    - Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare facility
    - Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare facility.
- Radiologic Events
    - Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area

B. Serious Avoidable Events (SAEs) or Hospital Acquired Conditions (HACs)

SAEs or HACs include, but are not limited to the following (for the comprehensive list visit the CMS website):

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Hospital Acquired Infections or Injuries including, but not limited to the following:
    - Catheter-Associated Urinary Tract Infection (UTI)
    - Vascular Catheter-Associated Infection
    - Surgical site infections:
        - Following Coronary Arty Bypass Graft (CABG)
        - Following Bariatric Surgery for Obesity
        - Following Orthopedic procedures (e.g., spine, neck, shoulder, elbow)
        - Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement

II. Review of Never Events, SAEs, or HACs

PacificSource will review all cases that are referred for a Never Event, SAE, or HAC. If, after a review of the case, it is determined that a Never Event, SAE, or HAC took place, PacificSource will reduce reimbursement from the hospital and/or provider. In accordance with the Recovery Audit Policy, PacificSource will make every attempt to identify and recover payment on claims within one-year of the determination of the event. However, PacificSource reserves the right to audit claims beyond the one-year time frame depending on the circumstances.

III. Reimbursement after a Never Event, SAE, or HAC Occurs

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 happens:

- 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;
- Readmission is required as a result of an adverse event that occurred in the same facility.

Medicaid

PacificSource Community Solutions follows Oregon Administrative Rules (OAR) 410-125-0450 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.

IV. Claims Information

CMS created a reimbursement guideline to end payment for extra care resulting from medical mistakes, otherwise known as HACs. This reimbursement guideline applies only to the care made necessary by the SAE or Never Event. These conditions are handled at the lower-paying diagnostic related group (DRG) when the condition is not POA and is the only major complication/co-morbidity reported.

In order to identify and monitor avoidable hospital conditions, the inclusion of the appropriate ICD-10 CM code and the POA indicator is 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 the condition is present on admission

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

1 = Exempt from POA reporting.

Definitions

Never 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.

Serious Avoidable Events (also known as Hospital Acquired Conditions) - events that result in additional procedures, increased level of care, and/or increased length of stay, which could have been reasonably prevented by applying evidence-based guidelines.

Related Policies

Adverse Events – Provider Quality Events

Recovery Audit Policy

References

Agency for Healthcare Research and Quality (AHRQ). (March 2020). A Critical Analysis of Existing and Emerging Patient Safety Practices. https://www.ahrq.gov/research/findings/making-healthcare-safer/mhs3/index.html

Centers for Medicare & Medicaid (CMS). (9/06/2023). Hospital-Acquired Conditions. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions

Centers for Medicare & Medicaid (CMS). (9/06/2023). ICD-10 HAC List. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs

Centers for Medicare & Medicaid Services (CMS). (9/06/2023). Hospital-Acquired Conditions (Present on Admission Indicator) https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac

Centers for Medicare & Medicaid (CMS). (2023). Publicly Reported DRA HAC Measures: Frequently Asked Questions. https://www.cms.gov/files/document/frequently-asked-questions-publicly-reported-deficit-reduction-act-dra-hospital-acquired-condition.pdf

National Quality Forum. Serious Reportable Events aka “Never Events”. Available at: https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx

National Quality Forum. Serious Reportable Event in Healthcare 2006 Update. Available at: https://www.qualityforum.org/Publications/2007/03/Serious_Reportable_Events_in_Healthcare%E2%80%932006_Update.aspx

Deficit Reduction Act of 2005. Hospital Quality Improvement. Section 5001 (c). https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf

The Leapfrog Group. (04/01/2021). Factsheet Never Events. https://ratings.leapfroggroup.org/sites/default/files/inline-files/2021%20Hospital%20Never%20Events%20Fact%20Sheet.pdf.

Appendix

Policy Number:

Effective: 2/1/2020 **Next review:** 1/1/2025

Policy type: Enterprise

Author(s):

Depts.: Health Services, Provider Network

Applicable regulation(s): Deficit Reduction Act (DRA) § 5001(c), OAR 410-125-0450

Commercial Ops: 12/2023

Government Ops: 12/2023