# *Reimbursement Policy*

## Preventable Adverse Events

**REIMBURSEMENT POLICY NUMBER: 73**

**Effective Date:** 10/1/2023

**Last Review Date:** 7/2023

**Next Annual Review:** 7/2024



**INSTRUCTIONS FOR USE:** Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do no not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

## *SCOPE AND APPLICATION*

*Provider Type:*

☒ Professional Claims

☐ DMEPOS Suppliers

☒ All health care services billed on CMS 1500 forms

☒ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

☒ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

*Plan Product:*

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

**SCOPE:** Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

☒ DRG

☒ Modified DRG

☒ Percentage of billed charges/per diem

## POLICY STATEMENT

**Never Events/Serious Reportable Events (SREs)**

I. Never events/SREs (i.e wrong body part, wrong patient) are **not reimbursable**. Providers and facilities shall not request reimbursement for costs associated with never events (see Policy Guidelines for a list of Never Events/SREs events). This includes:

   A. All related services provided during the same hospitalization in which the never event occurred; **and**
   B. All services provided in the operating/procedure room where a never event occurred; **and**
   C. All providers in the operating/procedure room when the never event occurred who can bill individually for their services (e.g., surgeon, anesthesiologist, radiologist).

**Hospital Acquired Conditions (HACs) and Other Preventable Adverse Events**

II. Hospital acquired conditions or other preventable adverse events (not including the never events identified above) are **subject to review** in accordance with this policy (see Policy Guidelines for a list of reviewable HACs and preventable adverse events). Anticipated adverse events after high-risk non-elective procedures (e.g., major trauma) may be considered reimbursable.

III. HACs and adverse events determined to have been preventable are **not reimbursable to the higher diagnosis related group (DRG)**. The claim is processed as though the HAC or adverse event was not present.

## *POLICY GUIDELINES*

**DEFINITIONS**

**Table 1.**

| Definitions | |
|---|---|
| **Adverse Event** | An event in which care resulted in an undesirable clinical outcome-an outcome not caused by underlying disease-that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death.[1] |

| | |
|---|---|
| **Preventable Adverse Event** | An adverse event, which "could reasonably have been prevented through the application of evidence-based guidelines."[2] See Policy Guidelines for examples of preventable adverse events which will be reviewed in accordance with this reimbursement policy. |
| **Never Events/Serious Reportable Events (SREs)** | Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.[3] See Policy Guidelines for a list of Never Events/SREs events. |
| **Hospital Acquired Conditions** | A hospital-acquired condition (HAC) is one of several medical conditions a patient can develop during a hospital stay that was not present on admission (POA), such as a pressure sore or surgical site infection.[4] See Policy Guidelines for Centers of Medicare and Medicaid Services (CMS)-defined categories of HACs which will be reviewed in accordance with this reimbursement policy. |

**ADVERSE EVENTS**

An event in which care resulted in an undesirable clinical outcome-an outcome not caused by underlying disease-that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death.[1]

**Preventable Adverse Events**

An adverse event, which "could reasonably have been prevented through the application of evidence-based guidelines."[2]

Examples of preventable adverse events **(this list is not all inclusive of indications which may be reviewed in accordance with the reimbursement policy)**:

- Surgical adverse event that could have reasonably been prevented with a change in surgical technique or clinical judgment
- Surgical site infections on clean cases (e.g., breast biopsy)
- Nosocomial infections
- Error in the dose or administration of a drug

**Never Events/Serious Reportable Events (SREs)**

According to the National Quality Forum (NQF), "never events" (also referred to as Serious Reportable Events (SREs)) are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.[3,5,6] These include:

- Surgical or invasive procedure events
    - Surgical or invasive procedures on the wrong body part[7]

    - Surgical or invasive procedures on the wrong patient[8]
    - Wrong surgery or invasive procedure on patient[9]
    - Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)
- Product of Device Events
    - Death/disability associated with use of contaminated drugs
    - Death/disability associated with use of device other than as intended
- Patient Protection Events
    - Infant discharge to wrong person
    - Death or serious disability due to patient elopement
    - Patient suicide or attempted suicide resulting in disability
- Care Management Events
    - Death/disability associated with medication error
    - Maternal death/disability with low-risk delivery
    - Death/disability associated with hyperbilirubinemia
    - Death/disability due to spinal manipulative therapy
- Environmental Events
    - Incident due to wrong oxygen or other gas
    - Death/disability associated with use of restraints within facility
- Criminal Events
    - Impersonating a health care provider (i.e., physician, nurse)
    - Abduction of a patient
    - Sexual assault of a patient within or on facility grounds
    - Death/disability resulting from physical assault within or on facility grounds

**Hospital Acquired Conditions (HAC)**

As required by Section 5001(c) of the Deficit Reduction Act of 2005, CMS has identified the following 14 categories of HACs because they are (a) high cost or high volume or both (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.[10]

For discharges occurring on or after October 1, 2008, IPPS hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (that is, the condition was not Present on Admission—see definition below). The case is paid as though the secondary diagnosis is not present.[11]

CMS-Defined Categories of HACs **(this list is not all inclusive of indications which may be reviewed in accordance with the reimbursement policy)**:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers

5. Falls and Trauma. Examples:
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Catheter-Associated Urinary Tract Infection (UTI)
7. Vascular Catheter-Associated Infection
8. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
9. Manifestations of Poor Glycemic Control. Examples:
    a. Diabetic Ketoacidosis
    b. Nonketotic Hyperosmolar Coma
    c. Hypoglycemic Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    a. Total Knee Replacement
    b. Hip Replacement
11. Surgical Site Infection Following Bariatric Surgery for Obesity. Examples:
    a. Laparoscopic Gastric Bypass
    b. Gastroenterostomy
    c. Laparoscopic Gastric Restrictive Surgery
12. Surgical Site Infection Following Certain Orthopedic Procedures. Examples:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
13. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
14. Iatrogenic Pneumothorax with Venous Catheterization

## *BILLING AND CODING GUIDELINES*

**Never Events/Serious Reportable Events (SREs)**

Facilities and providers are required to report “never events”/SREs to The Company by submitting a no-pay claim with the modifiers identified below. The Company will also notify the facility and provider if an unreported “never event”/SRE is identified by us.

CMS has established the following modifiers to be used in the occurrence of three never events/SREs. The following modifiers should be appended to <u>all services</u> related to the never event/SRE.

- PA - surgical or invasive procedure on the wrong body part
- PB - surgical or invasive procedure on the wrong patient

- PC - wrong surgery or invasive procedure on patient

In addition to the modifiers listed above, the claim should also include one of the following diagnosis codes:

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

**Hospital Acquired Conditions**

Effective October 1, 2015, the ICD-10 Version 33 Hospital Acquired Condition (HAC) list replaced the ICD-9-CM Version 32 HAC list. The complete list of ICD-10 codes which are considered HACs is available for download at "ICD-10 HAC List".

Present on Admission

Present on admission indicators "N" and "U" result in assignment of the lesser paying DRG.

POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA.[12] POA indicator codes are used to identify whether or not each diagnosis was acquired during the inpatient hospital stay.

When an HAC occurs, all IPPS hospitals must identify the charges and/or days which are a direct result of the HAC. Current and valid POA Indicators (as defined by CMS below) must be included on all IPPS hospital claims. A POA indicator is assigned to both principal and secondary diagnoses.[11,12]

**Table 2.**

| Present on Admission | | |
|---|---|---|
| Indicator | Description | Payment |
| Y | Diagnosis was present at time of inpatient admission. | Payment is made for condition when HAC diagnosis is present. |
| N | Diagnosis was not present at time of inpatient admission. | No payment is made for condition when HAC diagnosis is present. |
| U | Documentation insufficient to determine if condition was present at the time of inpatient admission. | No payment is made for condition when HAC diagnosis is present. |
| W | Clinically undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission. | Payment is made for condition when HAC diagnosis is present. |

The Company will administer POA indicators for inpatient claims that are paid with a DRG payment structure or allow for a reduction in payment for non-DRG payment structures.

Documentation of the POA must come from the provider, physician, or qualified healthcare practitioner who is legally responsible for establishing the patient's diagnosis. POA information may not be gleaned from non-provider documentation such as nurses' notes, dietician reports, etc.

## CROSS REFERENCES

- Inpatient Hospital Readmissions, RP54

**The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.**

## REFERENCES


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## *POLICY REVISION HISTORY*

| Date | Revision Summary |
|---|---|
| 1/2023 | Policy updated to new format |
| 10/2023 | Annual review. Updated language to include term Serious Reportable Event (SRE). Expanded SRE/Never Event list. |