

HCC Life Insurance Company Adopts “Never Events” Policy

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HCC LIFE
INSURANCE COMPANY

Rationale

HCC Life Insurance Company (HCC Life) has adopted the policy to no longer reimburse for “never events” and hospital acquired conditions (HAC). HCC Life’s policy is consistent with and based on the policy of the Centers for Medicare and Medicaid Services (CMS).

In September 2008, HCC Life provided our clients a news article pertaining to why self-funded employers, TPAs, PPOs, and others should adopt Medicare’s policy of not paying for treatment to correct errors by hospitals and other healthcare facilities. Employers have a large stake in this issue, since it affects the well-being of their workforces, employee productivity, and their bottom lines. For nearly a decade, The Leapfrog Group and The National Quality Forum (NQF) have focused their efforts in identifying “never events” with the ultimate result being that medical hospitals and facilities are accountable for the services they provide and in which they seek payment. Based on the National Quality Forum (NQF) “never events” definition, the Leapfrog Group encourages hospitals to adhere to the following initiatives:

- Apologize to the patient and/or family affected by the never event.
- Report the event to at least one of the following agencies: the Joint Commission, a state reporting program for medical errors and/or a Patient Safety Organization.
- Perform a root cause analysis consistent with instructions from the chosen reporting agency.
- Waive all costs directly related to the serious reportable adverse event.

Background

The National Quality Forum (NQF) is a non-profit national coalition of physicians, hospitals, businesses, and policy-makers asked by the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) to identify a set of patient safety measurements that should comprise a basic component of a medical errors reporting system. In 2002, NQF identified 27 “never events” and later in 2006, they revised the list to 28 events. NQF defines “never events” as “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.”

HACs Defined

A hospital acquired condition (HAC) is a reasonably preventable condition, which was not present or identifiable at the time of hospital admission, but was present during discharge. In general, HACs fall into several categories:

- Those that are high cost, high volume, or both, as determined by CMS
- Those identified through the International Classification of Diseases, 9th Revision, Clinical Modification coding (ICD-9-CM) as “complicating conditions” (CCs) or “major complicating conditions” (MCCs) that, when present as secondary diagnoses on claims, result in a higher-paying Medicare Severity Diagnosis-Related Groups (MS-DRG)
- Those that are reasonably preventable

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As a prelude to implementing the no payment policy for HACs, CMS has issued an expanded list of HACs for which it will no longer provide payment.

- Object left in patient during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Stage III and Stage IV Pressure Ulcers
- Vascular-catheter-associated infection
- Surgical site infection (specifically mediastinitis after coronary artery bypass graft surgery)
- Hospital-acquired injury due to external causes (fractures, dislocations, intracranial injury, crushing injury, burns, and other unspecified effects)
- Surgical site infections following certain orthopedic procedures and bariatric surgery for obesity
- Manifestations of poor blood sugar control, such as diabetic ketoacidosis and hypoglycemic coma
- Deep vein thrombosis or pulmonary embolism associated with total knee and hip replacement procedures

Never Events Defined

HCC Life's position is that the treatment/care and costs associated with these "never events" are not medically necessary as defined by the HCC Life's medical stop loss policy and will not be reimbursed by HCC Life. The definition reads:

Medically Necessary. A procedure, treatment, service, supply, equipment, drug, or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty, or primary area of practice, and;
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and;
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigational.

How CMS Determines a Never Event

First, you should identify if a condition was Present on Admission (POA). Effective October 1, 2008, CMS mandated diagnosis codes that hospitals were required to track in order to determine conditions that are Present on Admission. This mandate allows Medicare to create reduced payment Diagnosis-Related Groups (DRG) for post-admission diagnoses that should never have occurred. CMS issued various sets of instructions in 2007 requiring Inpatient Prospective Payment Systems (IPPS) hospitals to submit POA data for all diagnosis codes on Medicare claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting available at the web site: <http://www.cdc.gov/nchs/data/wh/ftp/ftp/cd9/icdguide07.pdf> (POA reporting guidelines begin on page 92). Information regarding CMS's phased implementation of POA indicator reporting and application of the POA reporting options are available at: <http://www.cms.hhs.gov/HospitalAcqCond>.

There are five POA indicator reporting options: “Y,” “N,” “W,” “U,” and “1.” These indicators are located in field 67 of the UB-04 and in segment K3 in the 2300 loop, data element K301 for the 8371 electronic submission.

POA Indicator Reporting Options	
Indicator	Definition
Y	Condition present on admission
N	Condition was not present on admission
W	Provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred
U	Medical record documentation is insufficient to determine whether the condition was present at time of admission
1	Unreported/not used, thus exempt from reporting (equivalent to a blank on the UB-04)

The NQF defines never events as “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.”

In order to meet said definition, the following criteria must be satisfied:

- **Unambiguous** — clearly identifiable and measurable, and thus feasible to include in a reporting system;
- **Usual preventable** — recognizing that some events are not always avoidable, given the complexity of health care;
- **Serious** — resulting in the death or loss of a body part, disability, or more than transient loss of a body function; and
- **Any of the following:**
 1. Adverse and/or
 2. Indicative of a problem in the health care facility’s safety systems and/or important for public credibility or public accountability.

The Adopted Never Events *(as of October 1, 2008)*

Adopted 28 Never Events	
Category	Definition
Surgical Events	1. Surgery performed on the wrong body part
	2. Surgery performed on the wrong patient
	3. Wrong surgical procedure performed on a patient
	4. Unintended retention of a foreign object in a patient after surgery or other procedure
	5. Intraoperative or immediately postoperative death in an ASA Class I patient

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Adopted 28 Never Events *(continued)*

Category	Definition
Product of Device Events	6. Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the healthcare facility
	7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used for functions other than as intended
	8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
Patient Protection Events	9. Infant discharged to the wrong person
	10. Patient death or serious disability associated with patient leaving the facility without permission
	11. Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
Care Management Events	12. 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)
	13. Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA – incompatible blood or blood products
	14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
	15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
	16. Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns
	17. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
	18. Patient death or serious disability due to spinal manipulative therapy
	19. Artificial insemination with the wrong donor sperm or wrong egg
Environmental Events	20. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
	21. Any 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
	22. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
	23. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
	24. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
Criminal Events	25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
	26. Abduction of a patient of any age
	27. Sexual assault on a patient within or on the grounds of a healthcare facility
	28. 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 healthcare facility

As originally stated, HCCL will follow the guidelines established by CMS and adopt the Never Events policy to all HCCL Policies.

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