

## SERIOUS REPORTABLE EVENTS (SRES)

### Policy

NHP does not reimburse services associated with serious reportable events (SRE) and / or “never events”.

To administer this policy, NHP recognizes, but is not limited to the serious reportable events identified by the National Quality Forum, *HealthyMass* and the CMS Medicare Hospital Acquired Conditions (HAC) and Present on Admission (POA) indicator reporting.

NHP will systematically monitor their data base for incidents of SREs.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and physicians performing the billable procedure(s) during which an “event” occurred.

NHP will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another physician.

### Limitations

The provider may not bill the member, the member’s next of kin, the member’s representative, or any other payer for care directly related to the occurrence of the serious reportable events and / or “never events”; the correction or remediation of the event; subsequent complications arising from the occurrence of the event.

The provider must waive any copayments or deductible due from the patient for the admission during which the SRE occurred.

Readmission to the same facility or for follow-up care provided by the same provider or a provider owned by the same parent organization within 30 days of the discovery of the event is not billable or reimbursable when the services are directly related to the occurrence of the event; the correction or remediation of the event; or subsequent complications arising from the occurrence of the event.

If after a documented review of the provider SRE incident report filed with the Commonwealth of Massachusetts, the provider determination is that the services related to the SRE are billable in whole or in part, the provider must identify those charges directly related to the SRE, with their corresponding diagnosis and procedure codes. NHP will review the report and make a reimbursement determination accordingly: full, partial or no payment for the case.

As defined in the provisions of the Provider’s contract with NHP, NHP may request additional information to facilitate further investigation of the SRE case.

NHP will recover, reduce or deny payments for SREs when one or more of the following criteria are met:

- The event is serious
- The event is usually preventable
- The event is within the control of the provider
- The event is adverse
- The event is indicative of a problem in the health care facility's safety systems and/or, important for public credibility or public accountability

## Definitions

**Adverse:** A negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

**Avoidable Hospital Conditions:** Hospital acquired conditions (HAC) which could reasonably have been prevented through application of evidence – based guidelines. These conditions are not present on admission to a hospital, but present during the course of the stay.

**ASA Class 1 Patient:** American Society of Anesthesiologists physical status indication of a normal healthy patient.

**CC (Co-morbidity or Complication):** An ICD-9 CM official convention in the tabular list of diseases, listing significant acute diseases, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases associated with extensive debility. When present as a secondary diagnosis at discharge, it will result in a higher MS-DRG.

**Event:** An adverse or damaging, discrete, auditable and clearly defined medical occurrence.

**HealthyMass:** A Massachusetts cross-agency initiative to build on health care reform which collaborative efforts focus on five key areas: ensuring access to care; containing health care costs; advancing health care quality; promoting individual wellness; and developing healthy communities. *A new policy was developed, to align payment policies for preventable complications, such as hospital-acquired infections and preventable readmissions* and adopted by four state agencies: the Office of Medicaid (MassHealth); Group Insurance Commission; Commonwealth Health Insurance Connector Authority; and Department of Correction. The non-payment policy will apply to the 28 serious reportable events identified by the National Quality Forum.

**Hospital Acquired Conditions (HAC):** The Deficit Reduction Act (DRA) of 2005 requires a quality adjustment in Medicare Severity Diagnosis Related Groups (MS-DRG) payment for certain hospital-acquired conditions requiring at least two conditions that: a) Are high cost or high volume or both; b) Result in the assignment of a case to an MS-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. For discharges occurring on or after October 1, 2008, twelve conditions have been identified. These 12 HAC conditions overlap, to some extent, with the 28 NQF Never Events.

ICD-9-CM: International Classification of Diseases, 9<sup>th</sup> Revision-Clinical Modification is based on the official version of the World Health Organization's 9<sup>th</sup> Revision, International Classification of Diseases (ICD-9). ICD-9 is designed for the classification of morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval. ICD-9 CM is a clinical modification of the WorldHealth Organization's 9<sup>th</sup> Revision, International Classification of Diseases (ICD-9).

The term “clinical” is used to emphasize the modification’s intent: to serve as a useful tool in the area of classification of morbidity data for indexing medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed only for statistical groupings and trend analysis.

**MCC (Major Complicating Condition):** An ICD-9 CM official convention in the tabular list of diseases, included in the MS-DRG prospective payment system. It is considered more intensive, and is a major and/or extensive severity rating. When present as a secondary diagnosis at discharge, it will result in a higher MS-DRG.

**NEC (Not elsewhere classified):** An ICD-9 CM official convention. This abbreviation in the tabular represents “other specified”. When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the “other specified” code.

**NOS (Not otherwise classified):** An ICD-9 CM official convention. This abbreviation in the tabular is the equivalent of unspecified.

**National Quality Forum (NQF):** A private organization whose membership includes the American Medical Association (AMA), and defines “Never Events” as listed below.

**Never Events:** Errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that risk of occurrence is significantly influenced by the policies and procedures of the health care organization. To be included in the list the following criteria must be met:

- Unambiguous-clearly identifiable and measurable, and feasible to be included in reporting system;
- Usually 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:
  - Adverse and/or
  - Indicative of a problem in the health care facility’s safety systems and/or, important for public credibility or public accountability.

The most current NQF list of Serious Reportable Events contains 28 distinct events included in the procedures table below. These 28 events were also cited in the CMS letter to State Medicaid Directors, dated July 31, 2008.

**Present on Admission (POA):** A condition that is present at the time the order of inpatient admission occurs. Conditions that develop during an outpatient encounter, including an Emergency Department, observation or outpatient surgery, are considered as present on admission. POA is applied to both primary and secondary diagnosis, as well as external cause of injury codes. Categories and codes exempt from reporting are late effects codes, normal delivery codes, V-codes and certain external codes (e.g. railway, motor vehicle, water transport, air and space transport.)

**Preventable:** An event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.

**Serious:** An event that results in death or loss of a body part, disability, or loss of bodily function lasting more than seven (7) days, or is still present at the time of discharge from an inpatient facility; or when referring to other than an adverse event, an event the occurrence of which is not trivial.

**Serious Reportable Event (SRE):** An event that could have reasonably been prevented through application of evidence-based guidelines. These conditions are not present on admission, or when the patient is treated, but occurs during the course of treatment or stay.

### Diagnosis and Procedures Codes

*Note: This list of codes may not be all-inclusive.*

Never Events	ICD-9 CM Code Description	ICD-9-CM Code
Surgery on Wrong Patient Surgery on Wrong Body Part Wrong Surgical Procedure	Performance of inappropriate operation	E876.5
Avoidable Hospital Conditions a.k.a. Serious Preventable Events	ICD-9 CM Code Description	ICD-9-CM Code and UB 04 Discharge Code
Surgical Events		
Unintended retention of a foreign object in a patient after surgery or other procedure.	Foreign body, accidentally left during procedure not elsewhere classified	998.4
	Acute reaction to a foreign substance accidentally left during a procedure	998.7
Intra-operative or immediately post-operative death in an ASA Class 1 patient	Discharge Status: Expired Instantaneous death	FL 17 Status 20 798.1
	Death occurring less than 24 hours from onset of symptoms, not otherwise explained	798.2
	Unattended death	798.9
Product or Device Events		
Patient death or serious disability associated with:	Discharge Status: Expired And / Or one of the following:	FL 17 Status 20
	contaminated drugs, devices or biologicals	Contaminated / infected blood, other fluid, drug or biological substance
the use/function of a device used in patient care for other than intended use/function	Mechanical failure of instrument or apparatus during procedure	E874.X
	Endotrach tube wrongly placed during anesthetic procedure	E876.3
	Failure to introduce/remove other tube/instrument	E876.4

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intravascular air embolism	Air embolism as complication of medical care, NEC	999.1
<b>Patient Protection Events</b>		
Infant discharged to wrong person	Other specified misadventures during medical care	E876.8
Patient death or serious disability associated with patient disappearance	Discharge Status: Expired Or Left Against Medical Advice or Discontinued Care. And Other specified misadventure during medical care	FL 17 Status 20  Status 07  E876.8
Patient suicide, or attempted suicide resulting in serious disability	Discharge Status: Expired And / Or Suicide and self inflicted injury	FL 17 Status 20  E950.X-E959
<b>Care Management Events</b>		
Patient death or serious disability associated with:	Discharge Status: Expired And / Or one of the following:	FL 17 Status 20
a medication error	Failure in dosage	E873.X
blood incompatibility	ABO, incompatibility reaction, not elsewhere classified Rh incompatibility reaction Other infusion and transfusion reaction Mismatched blood in transfusion	999.6 999.7 999.8 E876.0
manifestation of poor glycemic control	Secondary Diabetes w Ketoacidosis  Secondary Diabetes w Hyperosmolarity  Diabetic Ketoacidosis  Nonketotic Hyperosmolar Coma  Hypoglycemic Coma	249.10-249.11  249.20-249.21  250.10-250.13  250.20-250.23  251.0
failure to identify and treat neonatal hyperbilirubinemia	Preterm neonatal jaundice  Unspecified fetal/neonatal jaundice  Kernicterus not due to isoimmunization	774.2  774.6  774.7
pressure ulcers (decubitus ulcers)	Decubitus ulcer, Stage III and Stage IV	707.23-707.24
spinal manipulative therapy	Other and unspecified complication of medical care, NEC	999.9
artificial insemination with wrong donor sperm or egg	Performance of inappropriate operation	E876.5
the mother during labor and delivery in a low-risk pregnancy	Unspecified complication of labor and delivery	669.9X

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	Other and unspecified complications of the puerperium, NEC ( <i>sudden death of unknown cause during the puerperium</i> )	674.9X
<b>Environmental Events</b>		
Patient death or serious disability associated with:	Discharge Status: Expired And / Or one of the following:	FL 17 Status 20
electric shock or elective cardioversion	Electrocution and nonfatal effects of electric current	994.8
burn incurred from any source within the facility	Burns code range	940.XX-949.XX
a fall	Fracture code range  Dislocation code range  Intracranial injury code range  Crushing injury code range  Burns code range  Other and unspecified effects of external causes code range  Other fall from one level to another Fall from other tripping, slipping or stumbling Other and unspecified fall	800-829  830-839  850-854  925-929  940-949  991-994  E884.2-E884.6 E885.9 E888.0-E888.9
use of restraints or bedrails	Asphyxiation and strangulation ( <i>e.g. suffocation by bedclothes, pressure, constriction</i> )  Other effects of external causes (abnormal G forces/states, weightlessness)	994.7  994.9
Incident wherein a line designated for oxygen or other gas delivery to a patient contains the wrong gas or is contaminated by toxic substances	Other specified misadventure during medical treatment ( <i>performance of inappropriate treatment NEC</i> )  Accidental poisoning by other unspecified gasses and vapors	E876.8  E869.9
<b>Criminal Events</b>		
Patient care ordered by or provided by imposters as licensed health care providers	Other specified misadventure during medical care  Other and unspecified complication of medical care, NEC	E876.8  999.9
Patient abduction	Other child abuse and neglect Other adult abuse and neglect	995.59 995.85
Patient sexual assault	Assault by other specified means And either of:	E968.8

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	Child sexual abuse Adult sexual abuse	995.53 995.83
Patient or staff member death or significant injury resulting from physical assault	Discharge Status: Expired And / Or: Assault by other and specified means And either of: Child physical abuse Adult physical abuse	20  E968.8  995.54 995.81
<b>Hospital Acquired Conditions Tracked by CMS</b>	<b>ICD-9 CM Code Description</b>	<b>ICD-9-CM Code</b>
Catheter-Associated Urinary Tract Infection (UTI)	Infection/inflammatory reaction due to indwelling urinary catheter	996.64
<b>Excludes the following acting as CC/MCC:</b>		
	Candidiasis of other urogenital sites	112.2
	Acute pyelonephritis	590.10 590.11
	Renal and perinephric abscess	590.2
	Pyeloureteritis cystic	590.3
	Other pyelonephritis or pyonephrosis, NOS acute/chronic	590.80 590.81
	Acute cystitis	595.0
	Urethritis, not sexually transmitted, urethral syndrome	597.0
	Urinary tract infection, site not specified	599.0
Vascular Catheter-Associated Infection	Infection due to CV catheter	999.31
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	Mediastinitis  And one of the following procedure codes: Bypass anastomosis for heart revascularization	519.2  36.10-36.19
Surgical Site Infection Following Certain Orthopedic Procedures Spine Neck Shoulder Elbow	Complications of Surgical and Medical care NEC; Due to other internal orthopedic device, implant and graft Other post-op infection And one of the following procedure codes: Repair and plastic operations on joint structures	996.67  998.59  81.01-81.08, 81.23-81.24, 81.31-81.38,

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		81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	Morbid Obesity	278.01
	Other post op infection	998.59
	And one of the following procedure codes:	
	Lap gastroenterostomy	44.38
	Other gastroenterostomy	44.39
	Lap gastric restrictive bypass	44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Total Knee Replacement Hip Replacement	Iatrogenic pulmonary embolism and infarction	415.11
	Other pulmonary embolism and infarction	415.19
	Venous embolism and thrombosis of unspecified deep vessels of lower extremity	453.40-453.42
	And one of the following procedure codes:	
	Resurfacing hip	00.85-00.87,
	Hip replacement	81.51-81.52,
	Implantation of other internal limb lengthening device	84.54

\*This list of diagnosis is not exhaustive. SREs and POAs will automatically apply to any additional “events” added to the NQF SRE list, and/or the CMS Medicare Hospital Acquired Conditions (HAC) and Present on Admission (POA) indicator reporting.

**Present on Admission Indicators (POA)**

Indicator	Description	Payment
Y	Diagnosis present at time of inpatient admission	Payment will be made.
N	Diagnosis NOT present at time of inpatient admission	No payment will be made.
U	Documentation insufficient to determine if condition was present at time of inpatient admission.	No payment will be made.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at time of inpatient admission.	Payment will be made.
1	Exempt from POA reporting. Unreported/not used. This code is equivalent to a blank on the UB-04, however blanks are undesirable on data submitted via the 4010A.	Exempt from POA reporting
Z	The letter “Z” is used to indicate the end of the data element.	NA

**HCPCS Modifiers: SRE indicators**

Modifier	Descriptor	Comment
PA	Surgical or other invasive procedure on wrong body part	For procedures on or after 07/01/2009

PB	Surgical or other invasive procedure on wrong patient	For procedures on or after 07/01/2009
PC	Wrong surgery or other invasive procedure on patient	For procedures on or after 07/01/2009

**Billing Guidelines**

To identify and monitor “Never Events” and Serious Reportable Conditions, the appropriate ICD-9 diagnosis code(s) and Present on Admission (POA) indicators are required on all claims submitted to NHP, for services occurring on or after January 1, 2009, on claims submitted effective June 1,2009.

To identify and monitor surgery on wrong patient, surgery on wrong body part, or wrong surgical procedure, when applicable, the appropriate HCPCS modifier from the table above must be submitted in **the first modifier field** with the procedure code.

**Paper Claim: Required Field**

Submit the primary and secondary diagnosis codes (up to 5 digits) in the unshaded portion of form locator 67 A-Q of the UB-04 paper claim form.

Submit the POA indicator in position 8 (the shaded area) of form locator 67, of the UB-04 paper claim. Blanks are not acceptable

**Paper Claim Example**

FL 67 Primary Diagnosis Code		FL 67 POA	FL 67 A - Q Secondary Diagnosis Codes and POA														
66 DX	2449 67	Y	25001 A	N	29620 B	U	V1581 C	W	D								

**Electronic Claim: Required Field**

Submit the POA indicator in segment K3 in the 2300 loop, data element K301 for the 8371 electronic claim submission.

**Electronic Claim Examples**

Electronic claim with one (1) principal and five (5) secondary diagnoses should be reported as:

**POAYNUW1YZ**

POA	“POA” always required first, followed by a single indicator for every diagnosis reported on the claim.
Y	The principal diagnosis is always the first indicator after “POA”, In this example the diagnosis was present on admission.
N	The first secondary diagnosis was not present on admission, designated by “N”.
U	It was unknown if the second secondary diagnosis was present on admission, designated by “U”.
W	It is clinically undetermined if the third secondary diagnosis was present on admission, designated by “W”.
1	The fourth secondary diagnosis was exempt from reporting for POA, designated by “1”.
Y	The fifth secondary diagnosis was present on admission, designated by “Y”.
Z	The last secondary diagnosis indicator is followed by the letter “Z” to indicate the end of the data element.

Electronic claim with one (1) principal diagnosis without any secondary diagnosis should be reported as: **POAYZ**

<b>POA</b>	<b>“POA” always required first, followed by a single indicator for every diagnosis reported on the claim.</b>
Y	The principal diagnosis is always the first indicator after “POA”, In this example the diagnosis was present on admission.
Z	The letter “Z” is used to indicate the end of the data element.

**Exceptions to Policy Criteria**

Any changes to the CPT, HCPCS or Revenue Code descriptors, additional “events” added to the NQF SRE list, any updated CMS Medicare Hospital Acquired Conditions (HAC) and Present on Admission (POA) indicator reporting will be adopted by reference, if not contained in amended versions of this NHP policy.

**References**

CMS – Letter to State Medicaid Directors, SMDL # 08-004, July 31, 2008.

<http://www.cms.hhs.gov/SMDL/downloads/SMD073108.pdf>

CMS- Hospital Acquired Conditions (HCA) in Acute Inpatient Prospective Payment System (IPPS) Hospitals-Overview; ICN #901045.

<http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf>

CMS- Present on Admission (POA) Indicator reporting by Acute Inpatient Prospective Payment System (IPPS) Hospital; ICN # 901046.

[http://www.cms.hhs.gov/HospitalAcqCond/Downloads/POAFactsheet.p df](http://www.cms.hhs.gov/HospitalAcqCond/Downloads/POAFactsheet.pdf)

HealthyMass Serious Reportable Events Task Force Draft Policy Guidelines.

<http://www.mass.gov/?pageID=eohhs2pressrelease&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=The+HealthyMass+Initiative&sid=Eeohhs2&b=pressrelease&f=090617+non+payment+policy&csid=Eeohhs2>

ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2007; Official Coding Guidelines; Appendix I: Present on Admission Reporting Guidelines, pages 92-105.

National Quality Forum, Serious Reportable Events in Health Care – 2006 Update.

<http://www.qualityforum.org/pdf/reports/sre/txsreexecsummarypublic.pdf>

NHP Policy: Quality of Care Occurrences (QOCs) / Serious Reportable Events (SREs)

**Publication History**

<b>Topic:</b> Serious Reportable Events	<b>Owner:</b> Provider Network Management
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan's Provider Manual Billing Guidelines section for additional information on NHP's billing guidelines and administration policies. Questions may be directed to Provider Network Management at [prweb@nhp.org](mailto:prweb@nhp.org)