There’s a lot of discussion about Medicare no longer paying for “never events.” Surprisingly, so far, the policy has had little financial impact. Until recently, Medicare hadn’t given instructions about how claims for these events should be handled. There is also confusion about how Medicare defines a “never event” for payment purposes. OR Manager asked Keith Siddel, MBA, an expert on health care business operations, to respond to frequent questions. He is CEO of HRM Consulting, Creede, Colorado.

Q: How does Medicare define a “never event”? How does that differ from a HAC?

Siddel: There has been a lot of confusion about “never events” versus what Medicare calls “hospital-acquired conditions,” now to be called health care-acquired conditions, or HACs.

“Never events” were originally developed by the National Quality Forum as a list of 28 preventable events that should never happen to patients. Payers began saying, “If these are serious mistakes, we shouldn’t be paying for them.”

Congress took action in 2005, and from that Medicare began developing 2 programs for nonpayment of serious events:
• Never events. Currently, there are only 3 “never events” Medicare will not pay for: Surgery on the wrong body part, surgery on the wrong patient, and wrong surgery on a patient. Medicare recently issued national coverage determinations (NCDs), or national payment policies, for these 3 events. The NCDs went into effect July 6, 2009, for physicians and will go into effect October 1, 2009, for hospitals. They are posted at www.cms.gov (140.7, 140.8, and 140.9). The NCDs explain specifically how Medicare defines these events.
• HACs. For fiscal 2009, there are 10 categories of HACs for which Medicare announced it would reduce the DRG payment (sidebar). HACs have related ICD-9 codes and are determined using POA (present on admission) indicators. Examples are foreign objects retained after surgery, pressure ulcers, and certain types of surgical site infections. Medicare has said it will not provide additional payment for HACs if they are not present on admission.

Q: If we have a “never event,” how do we handle the claim? Do we write off the patient’s entire bill?

Siddel: Until recently, that wasn’t clear. Medicare just clarified its process in June 2009.

First, Medicare has defined more specifically what these wrong procedures
are, and I think it opens the door for a wider interpretation. The Medicare policy says: A surgical or other invasive procedure is considered to be the wrong procedure “if it is not consistent with the correctly documented informed consent for that patient.” There are a few exceptions, such as emergencies.

So they will really be comparing the procedure performed to the informed consent. That is how they will decide if it’s the wrong procedure. That means hospitals and OR personnel need to make sure the consent matches the procedure performed.

**Filing a claim**

Medicare recently spelled out the process for claims for these 3 never events. For inpatients, 2 claims need to be filed. The first claim has the covered services unrelated to the erroneous surgery. The second, completely distinct claim has all the services that were erroneous—that is a no-pay claim. On the no-pay claim, in the comment section, the hospital would put a 2-digit code:

- **MX:** Wrong surgery on a patient
- **MY:** Surgery on wrong body part
- **MZ:** Surgery on wrong patient.

For outpatients, the facility would append one of the following modifiers to the HCPCS code:

- **PA:** Surgery on the wrong body part
- **PB:** Surgery on the wrong patient
- **PC:** Wrong surgery on a patient.

**Related claims**

Another big change: Medicare has instructed its contractors (ie, fiscal intermediaries and MACs) to review all beneficiary claims related to these wrong-surgery events every 30 days for 18 months. If there are any related claims, the contractor is to “take appropriate action.” In other words, once a patient has had a surgical error, the contractor will look for related claims and deny these claims as appropriate.

But once again, Medicare’s instructions are incomplete. What if the patient has a wrong surgery at Hospital A but goes to Hospital B for follow-up care? Does that mean the contractor will deny payment to Hospital B? We need more clarification on that.

**Q** What about payment for HACs? How is that affecting hospitals?

**Siddel:** Not as much as you might think. The way it works is that for these conditions, Medicare and some other payers will look for a POA, which stands for “present on admission.” Thus, if a patient has a Stage 3 or 4 decubitus ulcer on admission, and the POA is recorded incorrectly as no, the payer will consider it a HAC. When processing the claim, Medicare will ignore the code for the decubitus ulcer when calculating all of the codes to make up the DRG.

But for 90% of patients who have a HAC, this actually doesn’t make much difference in the payment. Why? Most patients who have HACs have such complex conditions that just pulling out the code for the HAC doesn’t have much of a net effect on the DRG payment.

Medicare will have to change this in the future. It is not doing what they want-
ed it to do, which is to reduce the payment. We expect them to change it, perhaps as soon as next year.

Ten categories of HACs

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage 3 and 4 pressure ulcers
5. Falls and trauma
   • Fractures
   • Dislocations
   • Intracranial injuries
   • Crushing injuries
   • Burns
   • Electric shock
6. Manifestations of poor glycemic control
   • Diabetic ketoacidosis
   • Nonketotic hyperosmolar coma
   • Hypoglycemic coma
   • Secondary diabetes with ketoacidosis
   • Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection (UTI)
8. Vascular catheter-associated infection
9. Surgical site infection following:
   • Coronary artery bypass graft—mediastinitis
   • Bariatric surgery
     —Laparoscopic gastric bypass
     —Gastroenterostomy
     —Laparoscopic gastric restrictive surgery
   • Orthopedic procedures
     —Spine
     —Neck
     —Shoulder
     —Elbow
10. Deep vein thrombosis/pulmonary embolism
    • Total knee replacement
    • Hip replacement

Source: Centers for Medicare and Medicaid Services.

www.cms.hhs.gov/HospitalAcqCond/06_HospitalAcquired_Conditions.asp#TopOfPage
**Medicare defines wrong surgery**

These are summaries of Medicare’s definitions of wrong surgery for non-payment purposes. See the national coverage determinations for complete wording.

**Wrong surgical procedure performed on a patient**

“A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.”

*Exceptions:* Emergencies and changes in the surgical plan due to certain circumstances spelled out in the manual.

**Surgery on wrong body part**

“A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient, including surgery on the right body part but on the wrong location of the body” (e.g., left versus right appendages or organs) or at the wrong level (spine).

*Exceptions:* Emergencies and changes in the surgical plan due to certain circumstances spelled out in the manual.

**Surgery on wrong patient**

“A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.”