Understanding HACs and SREs for Quality Reporting and Reimbursement

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The focus on the delivery, measurement, and provision of quality patient care has led to several initiatives in the last few years that link reimbursement to quality care. These initiatives are often referred to as value-based purchasing, and they include present on admission (POA) indicators, hospital-acquired conditions (HACs), and serious reportable events (SREs).

These terms are often mistakenly used interchangeably. While they do overlap and can be interrelated, each has a distinct definition and purpose. This practice brief highlights the distinctions for each and how organizations should report and track them for quality reporting and reimbursement.

The brief also outlines the HIM responsibilities in these initiatives, which include understanding and explaining the regulatory environment, providing subject matter expertise in the application of the requirements, leveraging knowledge of reimbursement methodologies, and supporting the data analyses associated with improving the healthcare delivery system.

Background

The present on admission (POA) indicator and its terminology were introduced in the Deficit Reduction Act of 2005. The POA indicator identifies conditions present at the time the order for an inpatient admission occurs, including conditions that develop during an outpatient encounter such as an emergency department visit, observation, or outpatient surgery. A POA indicator is assigned to each principal and secondary diagnosis code according to the ICD-9-CM Official Guidelines for Coding and Reporting.

Hospital-acquired conditions (HACs) were also developed as a result of the Deficit Reduction Act of 2005. HACs are diagnoses determined by Medicare to be reasonably preventable. The conditions targeted by the Centers for Medicare and Medicaid Services (CMS) are high in cost, high in volume, or both; would result in assignment to a higher paying DRG when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines.

Medicare selected specific reasonably preventable conditions that have the potential to increase reimbursement under MS-DRGs. When these conditions are not reported as POA, payment may be reduced for the Medicare claim.

In 2002 the National Quality Forum issued a list of serious reportable events (SREs) that include “wrong” surgical, device, patient protection, care management, environment, and criminal events. SREs can occur as a result of injury or error from care management or failure to follow standard care or institutional practices and policies. These events can cause serious injury or death. SREs are frequently referred to as “never events,” as these events should never occur in a healthcare facility.

Several of CMS’s designated HACs are included on the National Quality Forum list of SREs. Overlap occurs between never events and HACs due to the fact that the condition or event must occur or be acquired in the facility to be considered a never event.

However, it is important to recognize distinct differences between the SRE and HAC lists. These include several SREs that are situations that cannot be represented using coded data; for example, patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility or abduction of a patient of any age.

A comparison of the National Quality Forum SREs and the CMS HACs appears in the table “SRE or HAC?” below. The table assists facilities in determining who may be internally responsible for collecting the appropriate information and who it

may be reported to.

Applying AHIMA's Standards of Ethical Coding

Accurate and complete coded data are critical to healthcare delivery, research and analysis, reimbursement, and policy making. The integrity of coded data and the ability to turn it into functional information requires that all users consistently apply the same official coding rules, conventions, guidelines, and definitions.[1]

Organizations must ensure adherence to industry coding standards and approved principles to generate coded data of the highest quality and consistency. To this end, HIM professionals must maintain an accurate and meaningful database reflective of the patient's encounter, including the severity of illness, resource use, and quality of care provided.

Billing and coding must remain compliant with the ICD-9-CM Official Guidelines for Coding and Reporting. Coding professionals should report codes on the billing abstract that fully represent the patient encounter. Diagnoses and procedures should not be inappropriately included or excluded for the purposes of determining reimbursement. This presents a challenge where coding drives reimbursement and the payer recognizes POA indicators.

AHIMA's Standards of Ethical Coding detail the expectations of professional conduct for coding professionals involved in the diagnostic and procedural coding or other health record data abstraction. Each standard is applicable to, and must be adhered by, coding professionals. Applicable standards and examples for reporting POA, HACs, and SREs are outlined below.

The standards state that coding professionals shall:

- Apply accurate, complete, and consistent coding practices for the production of high-quality healthcare data. The coder should accurately report diagnoses, procedures, POA indicators, and discharge status and not alter or suppress coded information. For example, when a HAC or SRE is clearly documented, the coder must always code the condition even when it may result in reduced payment.
- Report all healthcare data elements (e.g., diagnosis and procedure codes, POA indicators, discharge status) required for external reporting purposes completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines. For example, it would not be appropriate to report a POA as Y when there is no documentation to support the condition was POA.
- Query provider for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., POA indicator). For example, the POA indicator of U (meaning unknown or that documentation is insufficient to determine if condition was POA) should only be assigned rarely; therefore a provider query should be generated.
- Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations, and official rules and guidelines. For example, it is not acceptable to inaccurately code a diagnosis to avoid the reporting of a HAC or SRE.

There is never a valid reason for a coder to purposefully omit a code when the physician documentation clearly supports a codeable condition. Organizations' coding policies should reiterate compliant and ethical coding and reference the ICD-9-CM Official Guidelines for Coding and Reporting as well as the AHIMA Standards of Ethical Coding and interpretation section. The same standards apply to the POA indicator. It is not acceptable to falsely report the POA indicator Y when the condition was not present on admission.

Understanding Reimbursement Implications

Medicare Claims

Since October 1, 2008, CMS has reduced payment for acute care inpatient cases when designated HACs (recognizing that many HACs are a subset of the serious reportable events) are not POA and the condition would have increased the reimbursement for the specific case. Medicare follows the following steps to determine if a payment reduction will be made:

1. Identify claims that contain an ICD-9-CM code, or sets of codes, that CMS has included in the designated HACs.
2. Determine if any HAC ICD-9-CM code is reported with a POA of N or U.
3. Ignore these codes during DRG grouping process.
4. Assign lower MS-DRG, with associated lower weight and reduced reimbursement in cases where no other complication or comorbidity (CC) or major CC (MCC) is coded and the MS-DRG is driven based on the presence or absence of a CC/MCC. In some cases, omission of these codes will result in an MS-DRG with a lower payment weight.

In the case of three "wrong" surgical events included in the SREs, CMS has issued a noncoverage decision memorandum, stating that Medicare will not cover any of the three surgical events because they are not reasonable and necessary treatments for Medicare patients' medical conditions.

Effective October 1, 2009, one revised and two new E codes will be added to ICD-9-CM to identify "wrong" surgeries. These E codes are E876.5, Performance of wrong operation (procedure) on correct patient; E876.6, Performance of operation (procedure) on patient not scheduled for surgery; and E876.7, Performance of correct operation (procedure) on wrong side/body part.

CMS has implemented a new edit in the FY2010 Inpatient Prospective Payment System that will result in a claim rejection for a "wrong" surgery. The final rule also states that effective October 1, 2009, CMS will require the reporting of the three E codes that identify the "wrong" surgeries.

On July 24, 2009, CMS released transmittal 1778 that provides instructions and guidance for inpatient and outpatient claims processing. The link to transmittal 1778 is provided in the reference list.

Other Payers

The requirements for POA assignment to determine HAC (and where overlap occurs, SRE) on Medicare inpatient reimbursement are straightforward. However, other payers or state reporting requirements may be vague. Discussions surrounding hospital reporting of POA indicators and the payment implications regarding HACs and SREs to other payers are gaining momentum. Many states and payers have already adopted the Medicare requirements for HACs.

Many hospitals collect POA information for all patients, not just Medicare; however, based on payer, contract, or state requirements, the POA information may or may not be used on non-Medicare claims. Payers may or may not accept POA indicators, or they may have variations on which events may have an impact on reimbursement. For example, some payers have adopted some or all of the HACs, with many using a combination of HACs and SREs.

As a result of inconsistent payer requirements there is significant confusion among hospitals on how to implement procedures to identify these conditions while being compliant with coding and reporting guidelines and how to track and report cases that may or may not have a billing implication.

For information on POA indicators, descriptions, and CMS's HAC payment provisions, see "Understanding National Coverage Policies" in the June 2009 issue of the *Journal of AHIMA* .

The HIM Role

HIM professionals have specialized knowledge of data capture, data analysis, and reimbursement methodologies. This expertise will be essential in contract negotiations with payers. HIM professionals must understand the provisions in contract negotiations regarding HACs and SREs. They should review the following questions to help in their discussions with external payers:

- Will the contract address claim processing requirements or claims adjustments or a broader reporting requirement for all events, including those that are not represented in ICD-9-CM codes?
- Does the hospital collect the POA indicator for non-Medicare claims? Can the payer accept POA indicators? The POA indicator is essential in communicating whether a condition occurred during the hospitalization.

- Will the agreement address conditions identified as HACs for claim adjudication? If so, what payment methodology does the payer use? How will the reimbursement be affected? For example, if DRG-based, will the CMS HAC payment provision be followed? Or if percent of charges, will charges representing the HAC be removed from the claim?
- Is the payer including the "wrong" surgery SREs in the contract? If so, how will these claims be identified, claims processed, and reimbursement affected? Does the payer plan to include any SREs in the contract?
- How will SREs be reported that are not identified by ICD-9-CM code assignment? Are there other requirements being discussed as part of the contract, such as incorporating the Leapfrog Group's recommendation of reporting the occurrence of the SRE, apologizing to the patient and/or family, and performing a root cause analysis?
- What appeal rights does the hospital have?

It is imperative that payer contracts adhere to ethical coding practices. The following excerpts provide examples of contract terms that address payment policies and are consistent with official coding and reporting guidelines.

- When an SRE is not defined by ICD-9-CM codes, there will be no changes in the codes that are submitted.
- For payers that reimburse on a DRG basis, if an inpatient experiences a HAC, the POA assignment is N (was not POA) or U (documentation is insufficient to determine if the HAC was POA), and the HAC is the only complication or comorbidity on the claim, the hospital will be paid the applicable DRG amount, as if the HAC secondary diagnosis was not present.
- For payers that reimburse on percent of charges or per diem basis, the charges or days that are the direct result of the HAC will be billed as noncovered, so appropriate reduction in payment will be made and there will be no changes made to the coded data.
- In accordance with AHIMA's Standards of Ethical Coding, an HIM professional will refuse to delete the SRE from the claim even at the insistence of the payer.

In the unlikely event that the payer insists that the code be deleted, the provider organization should make an effort to work with the payer to change the payer's policy. For example, it can write a letter explaining why it is important to retain the code for a complete clinical picture of the patient's care, data analysis, statistics, and related uses. If the payer refuses to change its policy, this should be obtained in writing. In this situation, the code should not be deleted from the patient database or from other external data reporting processes.

Other internal processes and policies that organizations must consider include:

- Who determines that a HAC or SRE has occurred and how. Once determined, organizations must outline the steps to take.
- Who determines if a charge is removed from a bill.
- How the event will be reported when submitting the claim.

HAC or SRE cases should be flagged so that no bill is prepared for the case until it is investigated. The patient's bill should be reviewed to determine which, if any, charges should be removed based on the payer requirements.

Internal Uses of Coded Data

The POA indicator provides meaningful information for an organization's internal performance improvement initiatives. HIM professionals should reach out to leaders in quality, risk management, patient safety, infection control, case management, nursing, medical staff, finance, decision support, administration, and the board to ensure they are aware of the data and know how to interpret them.

Coded data allow the reporting and stratification of HACs and certain SREs by service area, DRG, provider, and any other data item available in the organization's healthcare information system. This information is useful for monitoring outcomes, generating quality dashboards and provider profiles, and targeting cases for individual case review or root cause analysis.

Coded data also reduce time needed for medical record review by quality, infection control, and risk management staff solely to identify HAC and certain SREs. The data may be used to supplement and validate current systems for event reporting and infection surveillance.

Finance may use the information in predicting reimbursement and preparing for contract negotiations with third-party payers. The use of the U indicator can be analyzed to identify opportunities for clinical documentation improvement and to evaluate the physician query process.

The organization can examine the interfaces between the healthcare information system and other internal systems to determine the appropriateness of and ability to include the POA indicator with other coded data. HIM professionals should be strong advocates for the use and understanding of this valuable information.

Glossary of Terms

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

Benchmark: an attribute or achievement that serves as a standard for other providers or institutions to emulate.

Error: an act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Event: discrete, auditable, and clearly defined occurrence.

Hospital-acquired condition (HAC): reasonably preventable condition that may be acquired during a hospital stay. Effective October 1, 2008, entities receive decreased payments for conditions that are not present on admission and are the only complication or comorbidity present.

Local coverage determination (LCD): decision by a Medicare administrative contractor, fiscal intermediary, or carrier whether to cover a service for the providers in their service area. The LCD provides guidance on whether or not a service is reasonable and necessary.

National coverage determination (NCD): the clinical conditions by which a service will be covered under Medicare coverage. National coverage determinations are binding by all Medicare carriers and contractors.

National Quality Forum (NQF): a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. NQF has broad participation from all parts of the healthcare system, including national, state, regional, and local groups representing consumers, public and private purchasers, employers, healthcare professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries, and organizations involved in healthcare research or quality improvement.

Patient safety organization (PSO): an organization that shares the goal of improving the safety and quality of healthcare delivery. Organizations that are eligible to become PSOs include public or private entities, profit or not-for-profit entities, provider entities such as hospital chains, and other entities that establish special components.

Present on admission (POA): condition present at the time the order for inpatient admission occurs. A **POA indicator** differentiates between conditions present at the time of admission from those conditions that develop during the inpatient admission. It is reported for all diagnoses reported on Medicare patients.

Serious reportable event (SRE): an event that results in death or loss of a body part, disability, or loss of a body function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility. SREs are sometimes referred to as “never events,” because they should not occur in a healthcare facility.

Standard of care: what the average, prudent clinician would be expected to do under certain circumstances.

External Data Uses

There has been an increasing emphasis on the use of claims data beyond the actual payment of the bill for services rendered. CMS, other payers, states, and accrediting agencies all use claims data either directly or indirectly to support quality measurement and public reporting.

Whether these initiatives rely on coded data to define patient populations for additional data collection or actually use ICD-9-CM codes to derive their measures, it is important to understand the consequences that decisions made for reimbursement will have on the ability to accurately and fairly represent hospital performance and outcomes of care.

Each year CMS reviews the current set of measures used for its Reporting Hospital Quality Data for Annual Payment Update program and proposes additions and replacement measures designed to cover an increasingly broader patient population and rely more heavily on claims data alone. Hospitals that do not satisfy the data submission requirements for the selected measures face a reduction of their annual payment update for that fiscal year. Of the 44 measures approved for FY 2010 payment determination, 16 are solely based on claims data.

Nine of the 16 claims-based measures use patient safety and inpatient quality indicators from the Agency for Healthcare Quality and Research. These measures rely on ICD-9-CM diagnoses and procedures to identify specific types of patient populations, such as mortality for surgical patients with a potential complication of care as defined by selected secondary diagnoses (Patient Safety Indicator 04).

While CMS's move to increase the number of claims-based measures is designed to reduce hospitals' manual data collection burden, it also emphasizes the reliance of these and other measure sets on the quality, completeness, and consistency of the data being submitted through the claims process. When data are collected by other mechanisms such as registries or electronic health records, the potential to compare information between these systems and the claim will allow for the ability to identify potential areas of under reporting or inconsistent reporting.

Voluntary accrediting agencies such as the Joint Commission and state agencies have selected measures to evaluate and report quality of care and patient safety data. The Joint Commission has aligned its Core Measures with CMS. A number of state agencies have used combinations of internally developed measures, AHRQ quality indicators, CMS, or Joint Commission measures to create measure sets for reporting.

The Leapfrog Group has also adopted a never events policy that describes the actions that hospitals should take whenever a rare medical error occurs. These actions include performing a root cause analysis and publicly reporting the event.

While this reporting can be through the Joint Commission, patient safety organizations, or a state reporting option, it reinforces the need not to suppress these data so that they can be used to improve the processes of care and help with developing system-wide solutions.

Becoming Involved

HIM professionals can provide subject matter expertise in a number of areas relating to the identification, reporting, and use of SREs and HACs. Understanding the classifications and coding systems available for reporting these type of data and how these data are used both within organizations and externally can provide valuable input when discussing how this information can and should be represented as part of the billing and claims submission process.

It is important that HIM professionals promote the importance of adhering to ethical coding guidelines and the potential consequences of implementing different approaches to billing HACs or SREs. This is key to ensuring that all stakeholders understand both the short- and long-term effects for failure to create a standard mechanism for these situations. HIM professionals can become involved in one or more of the following levels:

Organization

- Identify the key finance staff responsible for working with billing processes and get to know them.
- Gather information about what the current practice is for submitting claims for patients with an SRE or HAC and what variation may exist based on payer.
- Determine what payer or state guidelines exist for reporting SREs or HACs.

- Provide education to relevant staff on these payer and state guidelines as well as on existing Medicare guidelines.
- Provide education on AHIMA's Standards of Ethical Coding and the ways in which these data are used for both payment and quality and patient safety initiatives.
- Provide ongoing education on POA reporting requirements.
- Provide hospital executives with reports on incidence of HACs and SREs and work with finance staff to determine and report on reimbursement impact.

State (AHIMA Component State Associations)

- Determine if the CSA is already involved or planning for a statewide correct coding initiative. There is strength in numbers, and a concerted effort to demonstrate the effect of inconsistent capture and reporting of SREs or HACs, through either the claims process or quality reporting, can make a difference.
- Offer services to educate members in the state about this issue and the importance of HIM involvement.

National (AHIMA)

- Join and participate in AHIMA's Communities of Practice to reach members across the country and discuss concerns, approaches, and best practices relating to the collection and use of SREs and HACs. Share tips and become involved with initiatives.
- Use resources available in the AHIMA Body of Knowledge, understand the issues, and educate yourself and others.

The HIM professional's background is invaluable in achieving and maintaining data of the highest quality. HIM professionals should be advocating and promoting the importance of accuracy, validity, and meaningful data collection, reporting, analysis, and uses.

SRE or HAC?

This table was developed by one facility to capture appropriate data to assist in reporting serious reportable events and hospital-acquired condition data. It is not intended to be all inclusive or involve all regulatory reporting.

NQF Serious Reportable Events	ICD-9 Codes	CMS Defined Hospital-Acquired Condition	Hospital Staff Responsible for Data Collection	Potential Party Reported To
Surgical Events				
Unintended retention of a foreign object in a patient after surgery or other procedure	998.4, 998.7	Yes	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, patient accounts, risk management
Surgery performed on the wrong body part (CMS National Coverage Determination)	E876.7 (new code for FY 2010)	No	Quality management, risk management, HIM coding	Centers for Medicare and Medicaid Services (CMS), patient accounts, risk management

Surgery performed on the wrong patient (CMS National Coverage Determination)	E876.6 (new code for FY 2010)	No	Quality management, risk management, HIM coding	CMS, patient accounts, risk management
Wrong surgical procedure performed on a patient (CMS National Coverage Determination)	E876.5 (revised title)	No	Quality management, risk management, HIM coding	CMS, patient accounts, risk management
Intraoperative or immediately post-operative death in an ASA Class I patient	-	No	Quality management, risk management, HIM coding	Patient accounts, risk management
Product or Device Events				
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	-	No	Clinical Engineering Quality management, risk management	FDA, voluntary reporting to the Joint Commission, possibly patient accounts, risk management
Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended	-	No	Clinical Engineering Quality management, risk management	FDA, voluntary reporting to the Joint Commission, possibly patient accounts, risk management
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	999.1	Yes	Clinical Engineering Quality management, risk management	FDA, voluntary reporting to the Joint Commission, possibly contact patient accounts, risk management
Patient Protection Events				
Infant discharged to wrong person	-	No	Clinical Engineering Quality management, risk management	Local law enforcement, voluntary reporting to the Joint Commission, risk management
Patient death or serious disability associated with patient elopements (disappearance)	-	No	Clinical Engineering Quality management, risk management	Local law enforcement, voluntary reporting to the Joint Commission, state department of health, risk management
Patient suicide or attempted suicide resulting in serious	-	No	Clinical Engineering Quality management, risk	Local law enforcement,

disability, while being cared for in a healthcare facility			management	voluntary reporting to the Joint Commission, state department of health, risk management
Care Management Events				
Artificial insemination with the wrong sperm or donor egg		No	Incident report	Quality management, risk management, patient
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)	-	No	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, possibly state board of pharmacy, state board of nursing, state medical board, risk management
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products	999.6	Yes	Quality management, risk management, HIM coding, patient discharge (expired status)	Red Cross, risk management
Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility	-	No	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, risk management
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	All applicable codes	Yes	Quality management, risk management, HIM coding, patient discharge (expired status)	CMS, patient accounts, risk management
Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	-	No	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, risk management
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	707.23, 707.24	Yes	Quality management, risk management, HIM coding	CMS, patient accounts, risk management
Patient death or serious disability due to spinal		No	Quality management, risk management	Risk management

manipulative therapy				
Environment Events				
Patient death or serious disability associated with a fall while being cared for in a healthcare facility	• 800-829 Fracture • 830-839 Dislocation • 850-854 Intracranial Injury • 925-929 Crushing Injury	Yes	Quality management, risk management, HIM coding, patient discharge (expired status)	Voluntary reporting to the Joint Commission, CMS, patient accounts, risk management
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	-	No	Quality management, risk management	Risk management
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	940-949	Yes	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, CMS, patient accounts, risk management
Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility	994.8	Yes	Quality management, risk management, HIM coding	Voluntary reporting to the Joint Commission, CMS, patient accounts, risk management
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	-	No	Quality management, risk management	State department of health, CMS, voluntary reporting to the Joint Commission, risk management
Criminal Events				
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	-	No	Administration, security, risk management, quality management	Respective licensing board, local law enforcement, risk management
Abduction of a patient of any age	-	No	Administration, security, risk management, quality management	Local law enforcement, risk management
Sexual assault on a patient within or on the grounds of a healthcare facility	-	No	Administration, security, risk management, quality management	Local law enforcement, risk management
Death or significant injury of a patient or staff member resulting from a physical assault	-	No	Administration, security, risk management, quality management	Local law enforcement, risk management

(i.e., battery) that occurs within or on the grounds of the healthcare facility				

Note

1. AHIMA. "Statement on Consistency of Healthcare Diagnostic and Procedural Coding." December 2007. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

References

AHIMA House of Delegates. "AHIMA Standards of Ethical Coding." September 2008. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Centers for Medicare and Medicaid Services (CMS). "CMS Coverage Email Updates." Available online at www.cms.hhs.gov/CoverageGenInfo/EmailUpdates/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1219457&intNumPerPage=2000.

CMS. "Decision Memo for Surgery on the Wrong Body Part (CAG-00402N)." January 15, 2009. Available online at https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222.

CMS. "Decision Memo for Surgery on the Wrong Patient (CAG-00403N)." January 15, 2009. Available online at https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221.

CMS. "Decision Memo for Wrong Surgery Performed on a Patient (CAG-00401N)." January 15, 2009. Available online at https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=223.

CMS. "Hospital Acquired Conditions (Present on Admission Indicator)." Available online at www.cms.hhs.gov/HospitalAcqCond.

CMS. "Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals." Medicare Learning Network. ICN# 901045. October 2008. Available online at www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf.

CMS. "Medicare Takes New Steps to Help Make Your Hospital Stay Safer." August 4, 2008. Available online at www.cms.hhs.gov/apps/media/press_releases.asp.

CMS. "Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals." Medicare Learning Network. ICN# 901046. October 2008. Available online at www.cms.hhs.gov/HospitalAcqCond/Downloads/POAFactsheet.pdf.

CMS. "Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient." Transmittal 1778. July 24, 2009. Available online at www.cms.hhs.gov/transmittals/downloads/R1778CP.pdf.

Department of Health and Human Services, CMS. "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates." *Federal Register*, August 19, 2008. Available online at www.access.gpo.gov/su_docs/fedreg/a080819c.html.

Department of Health and Human Services, CMS. "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2010 Rates." *Federal Register*, May 22, 2009. Available online at http://edocket.access.gpo.gov/2009/pdf/E9-10458.pdf.

Department of Health and Human Services, Office of Inspector General. "Adverse Events in Hospitals: Overview of Key Issues." December 2008. Available online at http://oig.hhs.gov/oei/reports/oei-06-07-00470.pdf.

National Quality Forum. “Serious Reportable Events in Healthcare—2006 Update.” 2007. Available online at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=1249.

National Quality Forum. “Serious Reportable Events (SREs) Transparency and Accountability are Critical to Reducing Medical Errors.” Available online at www.qualityforum.org/Projects/s-z/SRE_Maintenance_2006/Fact_Sheet_-_Serious_Reportable_Events_in_Healthcare_2005-2006_Update.aspx.

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