Understanding National Coverage Policies: Navigating the Maze of HACs, Serious Reportable Events, and Wrong Surgical Sites

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Present on admission indicators, hospital-acquired conditions, serious reportable events, and "wrong" surgical events are each hot topics. However, they also can be a hot topic together, because a number of these reporting requirements are interrelated. HIM professionals must understand each requirement and how it relates to the others, as well as how to communicate and apply these guidelines appropriately.

POA Reporting and HAC Reimbursement Requirements

The Deficit Reduction Act of 2005 requires that present on admission (POA) indicators be reported for all diagnoses reported on Medicare inpatient acute care claims for discharges beginning October 1, 2007. Other payers and state reporting agencies may require POA indicators be reported on all diagnoses submitted on inpatient claims.

Present on admission is defined as conditions present at the time the order for inpatient admission occurs. The indicator is intended to differentiate between conditions present at the time of admission from those conditions that develop during the inpatient admission.

The POA reporting options include:

- Y = yes (present at the time of inpatient admission)
- N = no (not present at the time of inpatient admission)
- U = unknown (documentation is insufficient to determine if condition was present at the time of admission)
- W = clinically undetermined (provider is unable to clinically determine whether condition was present on admission)
- 1/blank = exempt from POA reporting

The Deficit Reduction Act also mandated financial incentives to reduce hospital-acquired conditions (HACs), which are identified by reporting POA indicators. Medicare must choose specific reasonably preventable conditions that may be acquired during a hospital stay. As of October 1, 2008, Medicare must also reduce payment for cases where these conditions are reported as not present on admission and the condition would increase reimbursement.

Conditions selected for inclusion in the HAC payment provision are:

- Catheter-associated urinary tract infection
- Stage III and IV pressure ulcers
- Object left in after surgery
- Air embolism
- Delivery of incompatible blood products
- Mediastinitis after coronary artery bypass graft surgery
- Falls and trauma (e.g., fractures, dislocations, intracranial/crushing injury, burns)
- Vascular catheter-associated infection
- Surgical site infections following certain orthopedic procedures
- Surgical site infections following bariatric surgery
- Poor glycemic control

- Deep vein thrombosis/pulmonary embolism following certain orthopedic procedures

A complete list of ICD-9-CM codes for the above conditions can be found at www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf.

When calculating the MS-DRG assignment, codes representing the HAC condition will not be considered if the provider reports a POA indicator of N or U, indicating that the condition was not present on admission. In many cases, omission of these codes will result in an MS-DRG with lower payment weight.

Medicare has outlined 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, included in one of the selected HACs listed above
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 CC/MCC is coded, and the MS-DRG is driven based on the presence or absence of a CC/MCC

It is important to reiterate that only codes included in the above list of HACs reported with a POA of U and N are subject to reduced payment.

Serious Reportable Events

In 1999 the Institute of Medicine published the report *To Err Is Human*, which raised awareness of the effects of medical errors on the safety of patients as well as the increasing costs of healthcare. It was clear from this report of the need for methods to identify and quantify the types and consequences of medical errors as well as establish processes for their prevention.

Subsequently the National Quality Forum (NQF) published *Serious Reportable Events in Healthcare: A Consensus Report* in 2002, which described a list of adverse events that were considered to be serious, largely preventable, and of concern to both the public and healthcare providers. These events came to be known as “never events.”

NQF then created the consensus standards maintenance committee on serious reportable events to review and refine the list in order to keep it current. The most recent list, updated in 2006, contains 28 events grouped into six categories: surgical, product or device, patient protection, care management, environment, or criminal. NQF now labels these as serious reportable events (SREs), although many groups continue to use the term never events.

Various initiatives have been developed to standardize the reporting of these types of events as well as linking to payment policies. Currently at least 25 states require licensed healthcare facilities to report SREs. The reportable events vary by state, either using the complete NQF list, a subset, or a hybrid version.

The Centers for Medicare and Medicaid Services (CMS) initiated a program to reduce payments to hospitals for Medicare patients based on the presence of a HAC. The CMS list of HACs includes a number of SREs from the NQF list, such as retention of foreign body in a patient after surgery or other procedure. Other payers have also declared their intention to not pay for these types of events.

While healthcare providers support these initiatives, there is confusion as to how to implement claims procedures to identify the conditions, be compliant with coding and reporting guidelines, and track cases where an SRE occurred without requesting payment for the event. If, for example, a hospital never submits a bill for a case or a code for the condition that identifies an SRE, complete information regarding that patient is no longer available, nor does it accurately represent the patient’s encounter.

In addition, a number of SREs are types of events that cannot be identified through UHDDS data elements, including ICD-9-CM or other coding classifications. Examples of these events include infant discharged to wrong person or abduction of a patient.

NCDs for Three “Wrong” Surgical Events

On January 15, 2009, CMS issued coverage decision memorandums related to three surgical events that should never occur. (The national coverage decisions should be released shortly.) The specific surgical events are surgical or other procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient; and wrong surgery performed on a patient.

Via the coverage decision memorandums, CMS states that Medicare will not cover these three surgical events because they are not a reasonable and necessary treatment for the Medicare patient's medical condition. This policy does not apply to those situations that are considered emergent or require a deviation from the original surgical plan due to the discovery of pathology or an unusual physical configuration.

Coding professionals should review and become familiar with the definition of a surgical or invasive procedure outlined in the coverage decision memorandums. These are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. This applies to procedures that are minimally invasive (e.g., biopsy, excision) to multiorgan transplantation procedures.

To help prevent these events from occurring, the Joint Commission approved the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. The principal components include:

- Conducting a preprocedure verification process
- Marking the procedure site
- Taking a "time-out" immediately before the start of the procedure
- Adapting these steps to nonoperating room settings

More to Come

Look for additional information, clarification, and examples of HACs, SREs, and wrong surgical sites in the upcoming September practice brief. The brief will also explore the HIM professional's role in these areas, including ethical coding responsibilities.

More in the BoK

Read other articles on these reporting requirements online in the FORE Library: HIM Body of Knowledge. Log on through myAHIMA at www.ahima.org.

More on the CoPs

Discuss national coverage policies with colleagues in the coding Communities of Practice, also available through myAHIMA at www.ahima.org.

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