n05760

Never Events Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This policy outlines Network Health's process, for all lines of business, when services are billed for "never events".

Policy Detail:

I. Never events, also known as serious reportable events, are characterized as unambiguous, usually preventable, and may cause serious harm to members or participants. These adverse events may be indicative of a problem in a health care facility's safety system, or important for public credibility or public accountability.

II. Network Health follows the Centers for Medicare and Medicaid Services (CMS) and will not reimburse for "never events", or any costs associated with them.

III. Health care facilities and providers may not seek payment for these services from members or participants.

IV. **Inpatient Hospital Claims:** Network Health requires that "never events" be reported, however they may not seek payment for these services.

  A. To report, two claims will be required: one to identify the "never event" and another for the covered service/procedure that is unrelated to the "never event".

  B. The claim with the non-covered service/procedure related to the "never event" should be on a no-pay claim.

V. **Outpatient Hospital, Ambulatory Surgical Centers (ASCs), and Professional/Physician Claims:** Network Health requires that the appropriate surgical error modifier be appended onto all claim lines that are related to the erroneous surgery, and the correct diagnosis is billed on the claim.

  A. **PA Modifier**: Surgical or other invasive procedure on wrong body part.

    i. **Y65.51 ICD.10**: Performance of correct procedure (operation) on wrong side of body.

      a. 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 of that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level of the spine.

B. **PB Modifier**: Surgical or other invasive procedure on wrong patient.

i. **Y65.51 ICD.10**: Performance of wrong procedure (operation) on correct patient.

C. **PC Modifier**: Wrong surgery or other invasive procedure on patient.

i. **Y65.52 ICD.10**: Performance of procedure (operation) on patient not scheduled for surgery.

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

VI. Surgical and other invasive procedures 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.

VII. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation.

VIII. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization.

IX. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar.

X. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to discovery of pathology in close proximity to the intended site with the risk of a second surgery outweighs the benefit of patient consultation, or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae.)

XI. The following is a list of events that Network Health considers as “never events”.

1. Surgery or other invasive procedure performed on the wrong site.
2. Surgery or other invasive procedure performed on the wrong patient.
3. Wrong surgical or other invasive procedure performed on a patient.
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
5. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient.

6. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
7. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
8. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
9. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
10. Patient death or serious injury associated with patient elopement (disappearance).
11. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.
12. Patient death or serious injury 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 injury associated with unsafe administration of blood products.
14. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
15. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
16. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
17. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
18. Artificial insemination with the wrong donor sperm or wrong egg.
19. Patient death or serious injury resulting from irretrievable loss of an irreplaceable biological specimen.
20. Patient death or serious injury resulting in failure to follow up or communicate laboratory, pathology, or radiology results.
21. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
22. Any incident in which systems designated in oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
23. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.
24. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.
25. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
26. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
27. Abduction of a patient/resident of any age.

28. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
29. Death or serious 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 setting.

Definitions:

Never event – Never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients.

Regulatory Citations:

Centers for Medicare & Medicaid Services (CMS)

Origination Date: 4/1/2016
Update Date: 6/19/2024
Next Review Date: 6/19/2025