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Objective:

I. To facilitate safe patient care for all Tuality Health Alliance (THA) members.

II. To encourage and support provider efforts to develop risk reduction strategies.

Definition:

A Hospital-Acquired Condition (HAC), is an adverse occurrence in medical care that is clearly identifiable, preventable, and serious in its undesirable consequences for a patient. A Hospital-Acquired Condition indicates a real problem in the safety and credibility of health care facilities.

The Oregon Association of Hospitals and Health Systems (OAHHS) is committed to delivering safe care. Accordingly, Oregon hospitals, including those hospitals contracted with THA, agree not to seek payment for costs associated with the occurrence of a serious adverse event if the event was preventable and within hospital control.

This policy includes a list of serious adverse events as they will not be considered for payment. See policy bullet points V and VI for the Centers for Medicare & Medicaid Services and Oregon Association of Hospitals and Health Systems No-Pay Lists.

Policy:

I. Identifying and reporting HAC improves patient care. Each THA-contracted hospital facility should have policies for serious reportable events. These policies should address how the facility will prevent HAC and how it will respond if/when a patient sustains a serious and likely preventable injury while being cared for.

II. In accordance with the Oregon Administrative Rules, THA will notify healthcare organizations/facilities of identified potential adverse events. THA may request information from the organizations in order to perform reviews. All findings from investigations will be shared with the organization in order to provide opportunities for process and system improvements.

III. THA will not provide payment for identified HAC and providers should not seek payment for associated costs.

a. THA Case Management staff will conduct reviews of all identified occurrences of potential HAC based on the Centers for Medicare & Medicaid Services and

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Oregon Associations of Hospitals and Health Systems No-Pay Lists (refer to bullet points V and VI for these No-Pay Lists, respectively).

b. The principles used in identifying and reporting HAC, for which payment may be withheld, are:

1. The event is preventable.
   If there are practices that are effective in preventing a particular harm from occurring, and those practices could have been implemented by the hospital, the error or event would be considered preventable.
2. The event is within the control of the hospital.
   Errors that may have occurred in the manufacture of drugs, devices, or equipment, well before the material reached hospital doors, are examples of events that would be outside of hospital control.
3. The event is the result of a mistake made in the hospital.
   These include errors in which a hospital failed to successfully carry out a practice that would have, in all probability, prevented harm to the patient.
4. The event results in serious/significant harm.
   The facility policies for identifying preventable adverse events should be limited to those events that yield very serious results.

c. All findings of HAC reviews will be shared with the provider and health care organization where the potential HAC occurred.

IV. Should a provider appeal the denial of payment for an identified HAC, THA will follow THA Policy and Procedure V-10 DMAP Appeals.

V. CMS No-Pay Conditions List:

a. Foreign object retained after surgery;
b. Air embolism;
c. Blood incompatibility;
d. Stage 3 or 4 pressure ulcers, unless documented as present on admission;
e. Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, burns, and electric shock;
f. Catheter-associated urinary tract infections, unless documented as present on admission;
g. Vascular catheter-associated infections;
h. Surgical site infection related to:

1. Mediastinitis after coronary artery bypass graft (CABG);
2. A cardiac implantable electronic device (CIED);
3. Bariatric surgery, including:

i. Laparoscopic gastric bypass,
ii. Gastroenterostomy,
iii. Laparoscopic gastric restrictive surgery;

4. Orthopedic procedures involving the:
   i. Spine,
   ii. Neck,
   iii. Shoulder, or
   iv. Elbow;

i. Manifestations of poor glycemic control:
   1. Diabetic ketoacidosis,
   2. Nonketotic hyperosmolar coma,
   3. Hypoglycemic coma,
   4. Secondary diabetes with ketoacidosis,
   5. Secondary diabetes with hyperosmolarity;

j. Deep vein thrombosis or pulmonary embolism associated with total knee or hip replacement or resurfacing procedures;

k. Iatrogenic pneumothorax with venous catheterization.

V. OAHHS No-Pay List:

a. Surgical Events:
   1. Surgery performed on the wrong body part;
   2. Surgery performed on the wrong patient;
   3. Wrong surgical procedure performed on a patient;
   4. Retention of a foreign object in a patient after surgery or other procedure;
   5. Intraoperative or immediate postoperative death in an American Society of Anesthesiologists (ASA) Class I Patient.

b. Product or Device Events:
   1. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility;
   2. Patient death or serious injury associated with the facility's use of a device for functions other than those for which the device is intended;
   3. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

c. Patient Protection Events:
   1. Infant discharged to the wrong person;

   2. Patient death or serious injury associated with patient leaving the facility without permission;

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3. Patient suicide, or attempted suicide, resulting in serious injury while being cared for in a healthcare facility.

d. Care Management Events:
   1. Patient death or serious physical 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);
   2. Patient death or serious injury associated with a hemolytic reaction due to the administration of ABO incompatible blood or blood products;
   3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy;
   4. Patient death or serious injury associated with hypoglycemia, the onset of which occurs while the patient is being cared for by the healthcare facility;
   5. Death or serious injury associated with failure to identify and treat hyperbilirubinemia in newborns;
   6. Stage 3 or 4 pressure ulcers acquired after admission to the healthcare facility;
   7. Patient death or serious injury due to spinal manipulative therapy;
   8. Any perinatal death or serious physical injury unrelated to a congenital condition in an infant having a birth weight greater than 2500 grams.

e. Environmental Events
   1. Patient death or serious injury associated with an electric shock while being cared for in a healthcare facility;
   2. Any incident in which a line designated for oxygen or other gas delivered to a patient contains the wrong gas or is contaminated by toxic substance;
   3. Patient death or serious injury associated with a burn incurred from any source while being cared for in a healthcare facility;
   4. Patient death or serious injury associated with a fall while being cared for in a healthcare facility;
   5. Patient death or serious injury associated with the use of restraints or bedrails while being cared for in the healthcare facility.

f. Criminal Events:
   1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;
   2. Abduction of a patient of any age;
   3. Sexual assault on a patient within or on the grounds of a healthcare facility;
   4. Death or significant injury of a patient resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

References: Centers for Medicare & Medicaid Services (CMS)
National Quality Forum

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Oregon Association of Hospitals and Health Systems (OAHHS)
Oregon Health Authority Health Plan Services Contract
RAE Participation Agreement
American Hospital Association
THA Policy V-10 DMAP Appeals

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