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Originated Department	Clinical Operations

Hospital-Acquired Conditions and Never Events

Audience
Medical Management

Purpose
<p>Medical policies provide general support for applying Mountain Health CO-OP member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health CO-OP medical policy, the member document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health CO-OP medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health CO-OP reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>Hospital-acquired conditions (HAC) are not present when a patient is admitted or arrives at the hospital or other facility but occur during or after the stay and are usually preventable. HACs include conditions such as decubitus ulcers, urinary tract infections due to urinary catheters, surgical site infections, etc., as the list of HACs published and updated by the Center for Medicare and Medicaid Studies (CMS) in the Inpatient Prospective Payment System Final Rule. HACs include iatrogenic complications caused by providers or other health care personnel, including but not limited to air embolism, blood incompatibility, misplaced instruments, wrong side surgery or other such events, and serious reportable events (SRE). SREs are also known as “Never Events”. These are events considered preventable and usually result in serious harm to the patient.</p>

Mountain Health CO-OP reviews claims for Hospital Acquired Conditions (HACs), Never Events, and Iatrogenic Complications. This policy outlines the review process and coverage for these conditions.

Policy/Procedure

Mountain Health CO-OP does NOT COVER direct costs associated with Hospital-Acquired Conditions (as defined by CMS), Events, or Iatrogenic Complications.

Those direct costs identified as related to hospital-acquired conditions, never events, or iatrogenic complications will be removed from any DRG or other payments due to providers, with appropriate recalculation of payment for otherwise identified medically necessary covered services based on these considerations.

A. The current 14 CMS categories of HACs include:

- i. Foreign Object Retained After Surgery
- ii. Air Embolism
- iii. Blood Incompatibility
- iv. Stage III and IV Pressure Ulcers
- v. Falls and Trauma:
 - a. Fractures
 - b. Dislocations
 - c. Intracranial Injuries
 - d. Crushing Injuries
 - e. Burn
 - f. Other Injuries
- vi. Manifestations of Poor Glycemic Control:
 - a. Diabetic Ketoacidosis
 - b. Nonketotic Hyperosmolar Coma
 - c. Hypoglycemic Coma
 - d. Secondary Diabetes with Ketoacidosis
 - e. Secondary Diabetes with Hyperosmolarity
- vii. Catheter-Associated Urinary Tract Infection (UTI)
- viii. Vascular Catheter-Associated Infection
- ix. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- x. Surgical Site Infection Following Bariatric Surgery for Obesity:
 - a. Laparoscopic Gastric Bypass
 - b. Gastroenterostomy
 - c. Laparoscopic Gastric Restrictive Surgery
- xii. Surgical Site Infection Following Certain Orthopedic Procedures:
 - a. Spine
 - b. Neck
 - c. Shoulder
 - d. Elbow
- xiii. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

- xiv. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
 - a. Total Knee Replacement
 - b. Hip Replacement
- xv. Iatrogenic Pneumothorax with Venous Catheterization

Clinical Rationale

The term "Never Event" was first introduced in 2001 by Ken Kizer, MD, former CEO of the National Quality Forum (NQF), in reference to particularly shocking medical errors—such as wrong-site surgery—that should never occur. Over time, the term's use has expanded to signify adverse events that are unambiguous (clearly identifiable and measurable), severe (resulting in death or significant disability), and usually preventable. Since the initial never event list was developed in 2002, it has been revised multiple times, and now consists of 29 "serious reportable events" grouped into 7 categories:

- Surgical or procedural events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Criminal events

Most Never Events are very rare. For example, a 2006 study estimated that a typical hospital might experience a case of wrong-site surgery once every 5 to 10 years. However, when Never Events occur, they devastate patients—71% of events reported to the Joint Commission over the past 12 years were fatal—and may indicate a fundamental safety problem within an organization. Although individual events are uncommon, many patients still experience these serious errors on a population basis. A 2013 study estimated that more than 4000 surgical Never Events occur yearly in the United States.

The Joint Commission has recommended that hospitals report "sentinel events" since 1995. Sentinel events are defined as "an unexpected occurrence involving death or serious physiological or psychological injury, or the risk thereof." The NQF's Never Events are also considered sentinel events by the Joint Commission. The Joint Commission mandates performing a root cause analysis after a sentinel event. The Leapfrog Group recommends that in addition to an RCA, organizations should disclose the error and apologize to the patient, report the event, and waive all costs associated with the event.

Because Never Events are devastating and preventable, healthcare organizations are under increasing pressure to eliminate them. The Centers for Medicare and Medicaid Services (CMS) announced in August 2007 that Medicare would no longer pay for additional costs associated with preventable errors, including those considered Never Events. Since then, many states and private insurers have adopted similar policies. Since February 2009, CMS has not paid for any costs associated with wrong-site surgeries.

Never Events are also being publicly reported, with the goal of increasing accountability and improving the quality of care. Since the NQF disseminated its original Never Events list in 2002, 11 states have mandated reporting of these incidents whenever they occur, and an additional 16 states mandate reporting of serious adverse events (including many of the NQF Never Events). Healthcare facilities are accountable for correcting systematic problems that contributed to the event, with some states (such as Minnesota) mandating the performance of a root cause analysis and reporting its results.

The most recently available list of Never Events is available [here](#)

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. 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 (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities
3. PATIENT PROTECTION EVENTS
3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4. CARE MANAGEMENT EVENTS
4A. 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) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4B. Patient death or serious injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers
4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities
4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices
4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5. ENVIRONMENTAL EVENTS
5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5C. 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 (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS
6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/officebased practices
7. POTENTIAL CRIMINAL EVENTS
7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
7D. 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 (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities
Applicable Codes
<u>CPT Codes</u>
Too many codes to list.
<u>HCPCS Codes</u>
Too many codes to list.

Vendors
<ul style="list-style-type: none"> • Personify • HPS

References

1. https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalAcqCond/icd10_hacs.html
2. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html>;
3. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2006-Fact-SheetsItems/2006-05-18.html>
4. https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

Review/Revision/Approval History

Date	Description
7/2024	New Policy Approved
11/24/2025	Reviewed by Policy Committee

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