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**UPDATE: PENNSYLVANIA HOSPITALS TO PAY FOR MEDICAL MISTAKES – QUALITY OF CARE AT THE FOREFRONT**

*By: Mark H. Gallant, Esquire*  
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Prevention of medical mistakes is a cause celebre, and states are beginning to jump on the so-called “never event” bandwagon. Taking a highly proactive stance, Governor Edward G. Rendell recently announced that Pennsylvania acute-care general hospitals will not be reimbursed by the state Medicaid program for services resulting from medical errors. On January 14, 2008, Pennsylvania became just the third state to adopt a policy limiting Medicaid reimbursement of hospital costs resulting from hospital errors through Medical Assistance (“MA”) Bulletin 01-07-11, entitled “Preventable Serious Adverse Events” (“PSAEs”).<sup>1</sup>

The Bulletin does not by its terms apply to outpatient services, or to the Medicaid managed care organizations (“MCOs”) (although MCOs may seek to adopt these standards by contract). A PSAE is a term used to describe an event that should “never” occur in a hospital and that can be prevented. Under the guidelines, “preventable” means “an event that could have been anticipated or prepared for, but that occurs because of an effort or system failure.” “Serious” means an event occurring during an inpatient admission “that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge.” The policy uses National Quality Forum (“NQF”) standards as “a starting point for health care organizations to establish measures and actions to be taken to actively improve the safety of patient care.”

The NQF has identified 28 PSAEs, including surgical events, such as surgery performed on the wrong body part or patient; product or device events, such as use of contaminated drugs or devices; or patient protection events, such as an infant discharged to the wrong family. Preventable occurrences range from removal of instruments accidentally left in the body to catheter-associated urinary tract infections. Other categories are environmental events, such as a patient death associated with a burn, electric shock, or fall that occurs while the patient is cared for in a health care facility; care management events, such as a patient death or serious disability associated with a medication error; and criminal events, such as care ordered or delivered by someone impersonating a licensed health care provider. The complete list can be found in Attachment “A” to the Bulletin.

<sup>1</sup> The text of the MA Bulletin 01-07-11 regarding PSAEs is available at [http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/0036\\_73169.aspx?BulletinId=4300](http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/0036_73169.aspx?BulletinId=4300).

State policymakers believe that withholding payment to hospitals for the extra care that results from these medical errors will help to forge accountability. Under Pennsylvania's new policy, the Department of Public Welfare ("DPW") will deny payment for any care made necessary by a PSAE, and the Bulletin provides guidance to assure that payments are not made for PSAEs. Hospitals are required to follow CMS instructions regarding identifying Present on Admission ("POA") indicators for all diagnosis codes for claims submitted on or after January 14, 2008. The POA indicator will serve to identify which conditions were developed during a hospital stay. To ensure the appropriate payment is made, the hospital must indicate treatment that is the result of a PSAE by using the appropriate ICD-9 or external cause of injury ("E") diagnosis codes. Attachment "B" to the Bulletin lists some examples of these codes.

Every month, DPW will review claims with an ICD-9 diagnosis code or E codes that are suggestive of a PSAE. In conducting its review, DPW may request the MA recipient's entire inpatient medical record, which the hospital must submit within 30 days of a request. DPW also will review for PSAEs during the course of hospital utilization review and during its retrospective reviews of outlier claims, which claims are accompanied by the submission of medical records. If a hospital fails to submit these records, DPW may then seek to impose sanctions, including but not limited to payment denial or restitution. Reviews are expected to be completed within 90 days.

Effective January 14, 2008, Pennsylvania hospitals will have to absorb the cost of these serious mistakes, to the extent the resulting treatment is the "reason for the payment," or "results in a higher level of [DRG] payment or outlier fees." In addition to potentially reducing already inadequate Medicaid payments – estimated to cover only about 75% of average hospital costs for treating patients – the new policy will also increase the administrative burden that hospitals already face. From a purely legal standpoint, it is questionable whether the government can validly restructure payment rules and establish a host of new, and highly specific, "binding norms" through a mere Bulletin, and without full notice and comment rulemaking proceedings. That said, the hospital industry, through the Hospital and Health System Association of Pennsylvania and other trade groups have embraced the adoption of policies designed to reduce preventable errors, and worked collaboratively with DPW to bring this new policy to fruition. It therefore appears far more likely that the health care sector's emphasis will be on developing compliance policies and safeguards, rather than on contesting the new payment policy.

Pennsylvania's action also is in keeping with a national movement to align patient safety and payments. A formal regulation was promulgated by the Centers for Medicare & Medicaid Services ("CMS") in August 2007 which, effective October 1, 2008, will require Medicare to stop paying hospitals for care associated with eight specific medical errors and preventable conditions unless they are present on admission. Under the federal regulation, hospitals still will receive reimbursement for a hospital stay based on the inpatient prospective payment system payment method, however, they will not receive any *additional* payments for care resulting from such medical errors (such as, for

example, payment pursuant to a higher DRG rate). That rule also prohibits hospitals from passing these charges on to patients. The initiative was mandated by Congress in order to prevent Medicare from bearing the cost when a patient incurs a hospital-acquired condition that could have been prevented with proper care. Coincidentally, CMS recently announced that costs and mortality rates have dropped for hospitals participating in Medicare's voluntarily "pay-for-performance" quality incentive demonstration project, which may fuel a drive to transform such voluntary measures into ones that are mandatory.

*Please contact Mark H. Gallant, Katherine M. Layman, or Judy Wang in our Philadelphia office if you have any questions regarding this Alert.*

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