

## **Payment Guidelines on Serious Adverse Events**

July 2008

Maryland hospitals work every day to make patient care as safe and free from harm as possible. Evidence of the priority hospitals' place on patient safety is the creation of the Maryland Patient Safety Center. This Center is a collaborative partnership between the Maryland Hospital Association and the Delmarva Foundation, that brings Maryland health care providers together to work to make Maryland health care the safest in the nation. To further safeguard patient safety, the state of Maryland requires mandatory reporting of serious adverse events resulting in unexpected death or serious disability and an intensive internal review of what caused the problem. Hospitals too have taken extensive steps to avoid errors that harm patients.

Despite these individual and collective efforts, human error can and does occur. Certain types of serious adverse events that cause the patient significant harm are preventable and under the direct control of the hospital. While rare, they can have tragic consequences for the patient, some resulting in permanent disability or death.

As an extension of their patient safety programs many hospitals have put informal practices in place to waive payments when certain serious adverse events\* occur that result in serious disability lasting greater than seven days or death. To make this uniform, Maryland hospitals will voluntarily adopt a policy, effective September 1, 2008, agreeing to waive payment from patients, insurers, or other payors for the following seven serious adverse events. These events were selected because they clearly meet the four criteria listed below. The seven events, when they result in serious disability lasting greater than seven days or death, are:

- *Surgery on the wrong body part;*
- *Surgery on the wrong patient;*
- *Wrong surgical procedure;*
- *Unintended retention of a foreign object;*
- *An air embolism that occurs while being treated in a hospital;*
- *A medication error attributable to the hospital; and,*
- *A hemolytic reaction due to administration of incompatible blood or blood products.*

As part of the policy, whenever one of these seven serious adverse events results in a patient's death or serious disability, hospitals agree to waive payment for the entire hospital patient stay.

Beyond these seven specific types of serious adverse events, Maryland hospitals will individually evaluate, on a case-by-case basis, whether full or partial payment should be waived for other events. Hospitals will be guided in their consideration by the work of the National Quality Forum (NQF) and those serious adverse events that are reportable to the state's Office of Health Care Quality.

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\*Note: A serious adverse event, as defined by the state, is an event that results in death or serious disability, which means a physical or mental impairment that substantially limits one or more of the major life activities of an individual lasting more than 7 days or still is present at the time of discharge.

In making the decision whether to waive full or partial payment for these other events hospitals will use the following criteria to guide their decision:

1. **The error or event was preventable.** Hospitals should not be held accountable for something that could not be reasonably prevented by the hospital in the first place. An indepth, internal analysis may be required to determine preventability.
2. **The error or event was within the control of the hospital.** Hospitals should not be held accountable for errors that may have occurred, for example, in the manufacture of drugs, devices or equipment, well before the materials reached a hospital's doors. An indepth, internal analysis may be required to determine the source of the error.
3. **The error or event was the result of a mistake made in the hospital.** The event must clearly and unambiguously be the result of a mistake made or hospital procedures not followed, rather than something that could otherwise occur.
4. **The error or event resulted in patient death or serious disability.** The list of events should be limited to those that yield very serious adverse results.

This policy establishes a uniform approach for all Maryland hospitals. It is intended to send a clear message to patients that hospitals are committed to their safe care through the elimination of serious adverse events which are preventable and within the control of the hospital.

*These guidelines were adopted by the MHA Executive Committee on July 15, 2008.*