The Rogers Law Firm

July 1, 2008

CLIENT ADVISORY

MASSACHUSETTS ADOPTS NEVER EVENTS PAYMENT POLICY

The Office of Health and Human Services of the Commonwealth of Massachusetts recently adopted a state-wide plan to implement a new policy to no longer reimburse hospitals for certain hospital-acquired serious events. The list of twenty-eight (28) serious events closely aligns with the Centers for Medicare and Medicaid Services (CMS) proposed amendments to its existing "never events." The Massachusetts policy is created as part of the *HealthyMass*[1] initiative and has been adopted by four state agencies as well as BlueCross BlueShield of Massachusetts. Those agencies include: the Office of Medicaid ("MassHealth"); Group Insurance Commission; Commonwealth Health Insurance Connector Authority; and the Department of Correction. The new policy is set to take effect in each agency's next contract cycle, making Massachusetts the first state to develop a non-payment policy across state government. Various officials from the participating organizations assert that the uniformity across state agencies will not only save money, but will also improve healthcare quality throughout the Commonwealth by eliminating what they deem rare yet preventable incidents.

CMS announced a proposed amendment to its existing never events policy on April 14, 2008, recommending the addition of nine new conditions.[2] These recommendations derive from a list identified by the National Quality Forum ("NQF") as Serious Reportable Adverse Events ("never events"). The *HealthyMass* initiative adopts all 28 of the NQF never events, creating an even more stringent and detailed list of conditions. In addition, the Department of Public Health ("DPH") has expanded its serious incidents to include all 28 events. Given the impact of the national and now state-wide action to eliminate payments for these serious hospital-acquired conditions, healthcare providers must be aware of the 28 incidents that are no longer billable. A complete list of the never events set forth by NQF and adopted by the *HealthyMass* initiative is attached hereto. If you should have any questions regarding the *HealthyMass* initiative, please do not hesitate to contact any of the attorneys at The Rogers Law Firm.

This Newsletter is published by The Rogers Law Firm to keep its clients informed of developments in health law. The Newsletter should not be construed or relied upon as legal advice or legal opinion on any specific facts or circumstances. If you have any questions or concerns regarding the articles contained in the Newsletter or would like legal advice or legal opinion concerning a specific matter, please do not hesitate to contact any of the attorneys at The Rogers Law Firm, at 617.723.1100.

[1] *HealthyMass* is comprised of nine collaborating agencies: the Executive Office of Health and Human Services; Executive Office of Administration and Finance; Office of the Attorney General; Commonwealth Health Insurance Connector Authority; Division of Insurance; Group Insurance Commission; Massachusetts Health and Educational Facilities Authority; Massachusetts Development Finance Agency; and Department of Correction.

[2] See *CMS 2009 IPPS Proposed Rule: Changes Proposed to Stark Law, EMTALA and Hospital-Acquired Conditions*, The Rogers Law Firm Client Newsletter (April 2008, Vol. 20).

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Surgical Events
Surgery performed on the wrong body part
Surgery performed on the wrong patient
Wrong surgical procedure performed on a patient
Unintended retention of a foreign object in a patient after surgery or other procedure*
Intraoperative or immediately post-operative death in an ASA Class 1 patient[3]

Product or Device Events
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility*

Patient Protection Events
Infant discharged to the wrong person
Patient death or serious disability associated with elopement (disappearance)
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

Care Management Events
Patient death or serious disability 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)
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products*
Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility**
Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility*
Patient death or serious disability due to spinal manipulative therapy
Artificial insemination with the wrong donor sperm or wrong egg

Environmental Events
Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility*
Patient death or serious disability associated with a fall while being cared for in a healthcare facility*
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Criminal Events
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
Abduction of a patient of any age
Sexual assault on a patient within or on the grounds of the healthcare facility
Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility

[3] American Society of Anesthesiologists classification scale of 1-6, Class 1 indicating a "normal healthy patient."
* Indicates conditions currently recognized by CMS as never events.
** Indicates additional conditions in the CMS proposed amendment (April 2008).

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