



TEXAS HOSPITAL ASSOCIATION

BACKGROUND:

Hospital Reimbursement for Serious Adverse Events

Texas hospitals provide quality, safe patient care.

Texas hospitals are committed to patient safety and delivering high-quality care to every patient. However, on rare occasions, a serious adverse event occurs. When this happens, the hospital quickly identifies its cause, takes immediate action to prevent it from happening again, and attempts to address any harm caused to the patient.

Texas hospitals support uniform billing policies related to adverse events.

While hospitals have mechanisms in place to address serious adverse events from a patient care perspective, a uniform practice regarding billing/reimbursement in these situations does not exist. After careful consideration and discussion, the Texas Hospital Association Board of Trustees approved a policy at its May 2008 meeting which incorporates **five principles to guide hospitals in developing their own internal policies regarding billing for care related to a serious adverse event**. A copy of the **THA principles** is attached.

Ultimately, this is a national issue. THA supports development of a national framework for how hospitals should be reimbursed when a rare serious adverse event occurs. Creating a national standard would minimize administrative costs and create uniform expectations for all hospitals and payers, including government programs. The development of a national framework has begun through the Medicare hospital-acquired conditions model of reimbursement and the more recent Medicare National Coverage Determination, which would deny coverage for three of the National Quality Forum "never events." **THA supports the adoption of the Medicare model by state-sponsored and private health plans.** Texas hospitals believe this model represents a thoughtful approach which can result in reduction of errors in a cost-effective manner.

THA has shared its principles with the state's major health plans, most of which are trying to determine their own reimbursement policies for these unusual situations. Some health plans in other states are basing their policies on the National Quality Forum's list of so-called "never events," despite the fact that it was developed as a tool to help improve quality and never was intended to be used to review and deny claims. **THA's principles create accountability for events that are within the control of the hospital; the majority of the 28 NQF events cannot be completely controlled by the hospital and its employees' actions.** In addition, THA's principles ensure that a patient who is harmed receives appropriate follow-up care to resolve the problem, if possible. THA's discussions with the health plans have helped put the issues into perspective and given them insights into the development of more appropriate reimbursement guidelines.

THA's voluntary initiative complements the extensive patient safety activities in which hospitals already participate.

Hospital quality and complaint data should be more accessible to the public.

The Texas Hospital Association also believes the public should have full access to relevant hospital quality data or science-based measures focused on patient outcomes. Meaningful data empower consumers to compare and evaluate hospitals. Simply collecting quality data and posting it to a Web site is not enough. THA believes national initiatives like HospitalCompare and other private Web sites provide useful quality data to consumers, but more can be done with complaint and quality data reported to the Texas Department of State Health Services.

To date, much of the information collected by the state is difficult to locate or simply is not readily available for consumers. For example, in 2007, the Texas Legislature required hospitals to report health care-associated infections – a measure supported by THA; yet, no funds were appropriated by the state for TDSHS to collect, analyze and publish the data.

THA supports transparency, and Texas hospitals believe the state must invest in the personnel and technology to make collected, verified data available to the public in an efficient and user-friendly manner.



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Principles for Developing Serious Adverse Events Hospital Billing Policies

The following principles were adopted on May 16 by the THA Board of Trustees to help hospitals identify events for which payment or partial payment may be withheld. These guidelines apply only to the care made necessary by the serious adverse event, not the entire episode of care.

- 1) **The error or event must be preventable.** Hospitals should not be held accountable for something that could not be reasonably prevented by the hospital in the first place. A root cause analysis may be required to determine preventability.
- 2) **The error or event must be 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. A root cause analysis may be required to determine the source of the error.
- 3) **The error or event must be the result of a mistake made in the hospital.** The event must clearly and unambiguously be the result of a mistake made, hospital procedures not followed, and not something that could otherwise occur.
- 4) **The error or event must result in significant harm.** The events should be limited to those that yield very serious results.
- 5) **The error or event must be clearly and precisely defined in advance.** A greater level of specificity than included in the National Quality Forum list of 28 serious events is required for identifying events if those events would result in penalizing a hospital through non-payment. NQF definitions are too ambiguous for such strict accountability. Hospitals should develop specific policy to guide decision making regarding serious adverse events.

Examples of Events Which May Meet Adopted Principles

1. Surgery performed on a wrong body part.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient.
4. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
5. An infant discharged to the wrong person.
6. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
7. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life.
8. Artificial insemination with the wrong donor sperm or donor egg.
9. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.