



# Overview of MO HealthNet Regulation 13 CSR 70-15.200

*Patient Safety Organization Provisions*

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## Patient Safety Organization Provisions



Effective July 1, 2009, a MO HealthNet (MHN) policy stops or reduces payment for certain preventable serious adverse events and errors in medical care that are clearly identifiable, preventable and serious in their consequences.

The rule affects hospitals and ambulatory surgical centers that are MHN providers, and addresses:

- withholding or reduction in payment for defined events,
- submission of present on admission codes on claims
- contracting with a federally-designated Patient Safety Organization (PSO) to report “serious reportable events”, defined by the National Quality Forum (NQF), and “hospital-acquired conditions”, defined by the Centers for Medicare & Medicaid Services (CMS).

This overview addresses the regulation’s provision for working with a PSO. Additional information about the regulation is available at [www.sos.mo.gov/adrules/csr/current/13csr/13c70-15.pdf](http://www.sos.mo.gov/adrules/csr/current/13csr/13c70-15.pdf).

### **REPORTING TO A PATIENT SAFETY ORGANIZATION**

On or before January 1, 2010, all in-state and out-of-state hospitals and ambulatory surgery centers enrolled as MHN providers are to have a contract, subject to MHN review, with a federally-designated PSO to report the occurrence of a serious reportable event, the root cause of the event, and participate in PSO-related improvement strategies.

### **ADVERSE EVENTS INCLUDED IN THE RULE**

To be considered a serious and preventable event under the new rule, it must appear on either of the following lists of events, for which MHN may deny or reduce payment:

- The NQF’s list of serious reportable events (SRE)
- The CMS’s list of hospital-acquired conditions (HAC)

NQF-defined Serious Reportable Events	Additional Information from the 2006 NQF Update
1. Surgery performed on the wrong body part 2. Surgery performed on the wrong patient 3. Wrong surgical procedure on a patient	These specifications include what constitutes a wrong procedure and defines procedures that are considered a surgery, including minimally invasive or minor procedures, such as biopsies and endoscopies.
4. Foreign object left in a patient after surgery or other procedure	This event excludes objects that are intentionally left in the patient when the risk of removal exceeds the risk of retention.

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NQF-defined Serious Reportable Events	Additional Information from the 2006 NQF Update
5. Intra-operative or immediately post-operative death in a normal healthy patient	“Immediately postoperative” means within 24 hours of the procedure being completed, or 24 hours following administration of anesthesia, if surgery was not completed.
6. Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the health care facility	The contaminants must be detectable by generally used mechanisms, such as cultures and changes in pH.
7. 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 in a way other than as intended	This is intended to address events whether the use is intended or described by the manufacturers’ literature or not, including devices such as catheters, drains, infusion pumps, ventilators, etc.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility	Neurosurgical procedures known to present a high risk of intravascular air embolism are excluded.
9. Infant discharged to the wrong person	An infant is defined as a person less than 1 year old.
10. Patient death or serious disability associated with patient disappearance for more than four hours	Excludes events involving competent adults.
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility	The event must happen after admission.
12. Patient death or serious disability associated with a medication error (wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	This event includes the administration of known allergic drugs.

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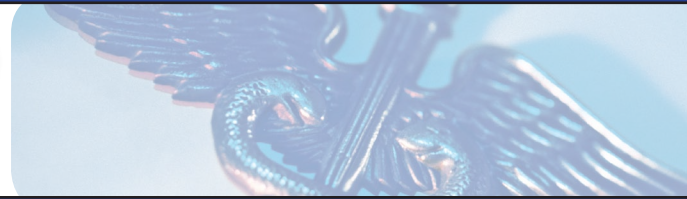
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NQF-defined Serious Reportable Events	Additional Information from the 2006 NQF Update
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	The incompatibility must be detectable by ABO/HLA matching.
14. Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a health care facility	This includes events that occur up to 42 days after delivery, excluding death from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy. The definition of “low-risk pregnancy” is in the NQF report.
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility	Hypoglycemia is defined as blood glucose level of less than 60 mg/dl.
16. Death or serious disability (Kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	Hyperbilirubinemia is defined as bilirubin levels greater than 30 mg/dl. Neonate refers to an infant in the first 28 days of life.
17. Stage III or IV pressure ulcers acquired after admission to a health care facility	Excludes progression from Stage II to Stage III if Stage II was present on admission.
18. Patient death or serious disability due to spinal manipulative therapy	Spinal manipulative therapy is defined in the NQF report.
19. Patient death or serious disability associated with an electric shock while being cared for in a health care facility	Excludes planned treatments, such as elective cardioversion.

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NQF-defined Serious Reportable Events	Additional Information from the 2006 NQF Update
<p>20. 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</p> <p>21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility</p> <p>22. Patient death associated with a fall while being cared for in a healthcare facility</p> <p>23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility</p> <p>24. Any instance of care ordered by or provided by someone impersonating physician, nurse, pharmacist, or other licensed healthcare provider</p> <p>25. Abduction of a patient of any age</p> <p>26. Sexual assault on a patient within or on the grounds of a health care facility</p>	<p>The NQF report provides no additional specifications or definitions for these events.</p>
NQF SREs – NOT INCLUDED IN THE MHN RULE	REASON FOR EXCLUSION
<p>Artificial insemination with the wrong donor sperm or donor egg</p>	<p>Artificial insemination is not covered by MHN.</p>
<p>Death or significant injury of a patient or staff member resulting from a physical assault (battery) that occurs within or on the grounds of a health care facility</p>	<p>MHN views this event as outside the health care facility’s control.</p>

Additional details are available by downloading the report, “Serious Reportable Events in Healthcare: 2006 Update”, at [www.qualityforum.org/publications/reports/sre\\_2006.asp](http://www.qualityforum.org/publications/reports/sre_2006.asp).

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Many of the following CMS-defined HACs included in the MHN regulation also are considered to be NQF SREs.

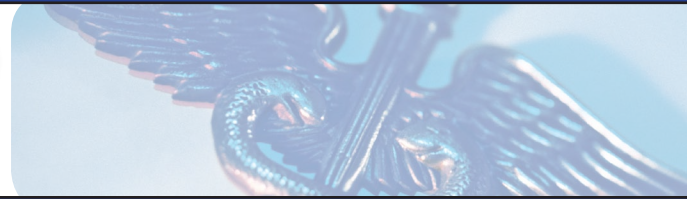
### CMS-Defined Hospital-Acquired Conditions as of December 15, 2008

Foreign object retained after surgery
Air embolism
Blood incompatibility
Stage III and IV pressure ulcers
Falls and trauma - fractures , dislocations, intracranial injuries, crushing injuries, burns, electric shock
Manifestations of poor glycemic control - diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
Catheter-associated urinary tract infection
Vascular catheter-associated infection
Surgical site infection following: coronary artery bypass graft (mediastinitis); bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery); orthopedic procedures ( spine, neck, shoulder, elbow)
Deep vein thrombosis (DVT)/Pulmonary embolism (PE) following total knee replacement and hip replacement

Additional information on these conditions is available at  
[www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf](http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf).

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### **OTHER MHN REGULATION PROVISIONS**

#### Payment

Payment for the defined events will only be withheld or reduced if an event:

- is determined to have been preventable
- resulted in serious harm
- was within the control of the health care facility
- occurred during an inpatient admission, outpatient hospital surgery or care at an ambulatory surgical center. Although events that occur during outpatient surgery are included in the rule, some outpatient encounters, such as an emergency room visit or a radiology exam are excluded.

The staff of MHN is expected to calculate payment denials or reductions, based on the facts of each event, followed by review by a MHN Division director. Pursuant to state law, the division's final decision on denial of payment is subject to review by the Administrative Hearing Commission.

In addition, payment denials will not be applied to care provided by another hospital if the patient is transferred or admitted to another facility.

#### Present on Admission (POA) Indicator

As of July 1, hospitals currently paid under Medicare's Inpatient Prospective Payment System (IPPS) must use the POA indicator on the UB-4 when submitting MHN claims. Providers not currently paid under IPPS — rehabilitation, psychiatric, long-term care hospitals, children's and critical access hospitals, and ambulatory care providers — are to begin submitting the POA indicators on MHN claims beginning July 1, 2010.

For more information, visit [www.cms.hhs.gov/HospitalAcqCond/Downloads/POAFactsheet.pdf](http://www.cms.hhs.gov/HospitalAcqCond/Downloads/POAFactsheet.pdf).

### **SUGGESTED NEXT STEPS**

- Assemble a team to oversee implementation of the rule provisions. Consider including finance, health information, patient safety, risk management, education and medical services staff.
- Appoint a staff member as the PSO contact.
- Review the enclosed contract for PSO services with the MOCPS, including review by legal counsel, as appropriate. Remember MHN providers are to have a signed agreement with a PSO by January 1, 2010.
- Use the enclosed guidelines to establish a patient safety evaluation system (PSES) and define patient safety work product (PSWP) to manage the flow of patient safety information to the PSO to maximize available legal protections.

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### **SUGGESTED NEXT STEPS** *(continued...)*

- Review and incorporate the NQF's definitions for adverse event, preventable, serious, and health care facility within policies and procedures, as appropriate.
- Develop policies and procedures to document adverse events and patient safety information for reporting to a PSO, incorporating PSES, PSWP and NQF and CMS definitions, as appropriate.
- Review the additional resources and references included in this Overview.
- Assess the coding and billing implications of the MHN rule, and involve health information and finance staff in policy and procedure changes, including assessment of education that may be needed for staff who document in the medical records, as well as coding staff.

### **ADDITIONAL RESOURCES**

Patient Safety and Quality Improvement Act of 2005, Public Law 109-41 109th Congress, at [www.pso.ahrq.gov/statute/pl109-41.htm](http://www.pso.ahrq.gov/statute/pl109-41.htm).

Coding Instructions - "ICD-9-CM Official Guidelines for Coding and Reporting", [www.cdc.gov/nchs/data/icd9/icdguide.pdf](http://www.cdc.gov/nchs/data/icd9/icdguide.pdf). See Appendix I, "Present on Admission Reporting Guidelines".

December 2008 report, "Adverse Events in Hospitals", U.S. Department of Health and Human Services, Office of Inspector General at [www.oig.hhs.gov/oei/reports/oei-06-08-00220.pdf](http://www.oig.hhs.gov/oei/reports/oei-06-08-00220.pdf).

Coding Hospital-acquired Conditions (Present on Admission), Centers for Medicare & Medicaid Services, [www.cms.hhs.gov/HospitalAcqCond/05\\_Coding.asp](http://www.cms.hhs.gov/HospitalAcqCond/05_Coding.asp).