



Serious Reportable Events Payment Policy

Policy

Fallon Community Health Plan (FCHP) follows the National Quality Forum's (NQF) definition of a Serious Reportable or "Never" Event. To be included on NQF's list, an event had to have been characterized as:

- Unambiguous—clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable—recognizing that some events are not always avoidable, given the complexity of health care;
- Serious—resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- Any of the following:
 - ✓ Adverse, and/or
 - ✓ Indicative of a problem in a health care facility's safety systems, and/or
 - ✓ Important for public credibility or public accountability.

FCHP **will not** reimburse for Serious Reportable Events.

Definitions

Serious Reportable Events (SRE) is defined as an event that occurs on premises covered by a provider's license that results in an adverse patient outcome, is clearly identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Preventable means events that could have been avoided by proper adherence to applicable patient safety guidelines, best practices, and hospital policies and procedures.

National Quality Forum (NQF) means the not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

FCHP will not reimburse for the below SREs as categorized by the National Quality Forum:

Surgical events:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure on a patient
4. Retention of a foreign object in a patient after surgery or other procedure
5. Intra-operative or immediately post-operative death in a normal-health patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)

Product or device events:

6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
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 other than as intended
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility

Patient protection events:

9. Infant discharged to the wrong person
10. Patient death or serious disability associated with patient elopement (disappearance)
11. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:

12. Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
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
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 (proposed 2009)
16. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
17. Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
18. Patient death or serious disability due to spinal manipulative therapy
19. Artificial insemination with the wrong donor sperm or wrong egg

Environmental events:

20. Patient death or serious disability associated with an electric shock while being cared for in a health care facility
21. 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
22. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility
23. Patient death or serious disability associated with a fall while being cared for in a health care facility

24. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility

Criminal events:

25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
26. Abduction of a patient of any age
27. Sexual assault on a patient within or on the grounds of a health care facility
28. 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 a health care facility

FCHP follows, but is not solely limited to, the National Quality Forum's list of SREs.

Providers will not be reimbursed for services provided as a result of an SRE occurring on premises covered by the provider's license if the hospital determines that the SRE was:

- a) preventable, and
- b) within the hospital's control, and
- c) unambiguously the result of a system failure.

A provider may seek reimbursement for services it provides that result from an SRE that did not occur on its premises; however, a provider that provides services resulting from an SRE occurring on premises of a separately licensed provider, may not charge or seek reimbursement for those services, if the treating facility and the responsible facility have common ownership or a common corporate parent.

Any dispute(s) arising between the hospital and FCHP shall be addressed through the provider appeals process.

Billing/coding guidelines

Providers must immediately suspend or rescind any SRE related claims to FCHP pending the preventability determination and notification requirements.

FCHP reserves the right to audit both professional and facility medical records at any time regarding SREs.

Referral/notification/preauthorization requirements

Within seven days of discovery of an SRE, a provider must notify FCHP by calling Provider Services at 1-866-ASK-FCHP, prompt 4. Providers will be expected to provide FCHP with a copy of the initial and updated SRE reports that are filed with the Department of Public Health.

The provider will also be expected to inform the member or the member's representative verbally and in writing about:

- the occurrence of the SRE, including unanticipated outcomes of care, treatment and services provided as the result of the SRE;
- the provider's policies and procedures and documented review process for making a preventability determination; and
- the option to receive a copy of the SRE reports filed with the Department of Public Health.

Place of service

All places of service.

Policy history

Origination date:	01/01/09
Previous revision date(s):	N/A
Connection date and details:	07/01/09 – changed policy name from Never Events to Serious Reportable Events; updated language in the Policy, Definitions, Reimbursement, and Referral/notification/preauthorization requirements sections.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.