

Medicare/Medicaid Fraud Update



Medicare/Medicaid Fraud Issues

- Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.
- The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. (DHHS)

Medicare/Medicaid Fraud Issues

- In Medicare, the most common forms of fraud includes:
 - Billing for services not furnished
 - Misrepresenting the diagnosis to justify payment
 - Soliciting, offering, or receiving a kickback
 - Unbundling or "exploding" charges
 - Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
 - Billing for a service not furnished as billed; i.e., upcoding

Medicare/Medicaid Fraud Issues

- **False Claims Act, 18 U.S.C. § 287.**
- Under this statute, any health care provider who presents a false or fictitious claim or demand to the government seeking reimbursement for medical goods or services can be liable. The prosecutor need only prove that the provider intentionally submitted the claim knowing that it was false, fictitious or fraudulent. This can be shown by showing that the claim was for goods or services that were not provided, were not provided as stated, or were provided but not medically necessary.

Medicare/Medicaid Fraud Issues

- The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
 - a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
 - b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.
- The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government

Medicare/Medicaid Fraud Issues

- Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
 - a) was not provided as claimed; and/or
 - b) the claim is false or fraudulent.
- This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

Medicare/Medicaid Fraud Issues

- Medicaid Fraud Control Unit (MFCU)
 - The enactment of the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 authorized the establishment of, and Federal funding for, the State Medicaid Fraud Control Units (SMFCUs). Currently, 49 States and the District of Columbia participate in the Medicaid fraud control grant program through their established SMFCU. The majority of the Units are located within the Office of State Attorneys General. A small number of the Units are located in various other State Agencies. **The mission of the Medicaid fraud units is to investigate and prosecute Medicaid provider fraud and incidences of patient abuse and neglect**

Medicare PPS Eligibility Criteria

Medicare/Medicaid Fraud Issues

- **Technical Eligibility**
 - Beneficiary is enrolled in Medicare Part A and has days available
 - A three (3) day qualifying hospital stay
 - Placed in Medicare certified bed within 30 days of hospital discharge or resume covered level of care within 30 days of last Medicare covered day
- **Clinical eligibility**
 - Need for and receipt of daily skilled services that must be reasonable and necessary
 - Provided by or under the direct supervision of skilled nursing or rehabilitation professionals
 - Services must be related to the hospital stay

Medicare/Medicaid Fraud Issues

- **Technical Eligibility**
 - **3-day Prior Hospitalization Requirement**
 - Must have been a hospital patient for 3 consecutive calendar days prior to admission
 - Day of admission is counted as hospital day
 - Day of discharge is not counted as hospital day
 - Skilled services necessary for a condition treated during hospital stay or for condition that arose while in SNF for treatment of condition previously treated in hospital

Medicare/Medicaid Fraud Issues

■ Technical Eligibility (cont.)

□ 30-day Transfer Requirement

- Services must begin within 30 days after discharge from hospital that included 3-day stay
 - Day of discharge from hospital (SNF readmission date) is not counted
- Resident resumes skilled level within 30 days after last covered Medicare SNF day
- Period in excess of 30 days may be acceptable if resident's condition made it medically inappropriate to begin active course of treatment and is predictable at time of discharge

Medicare/Medicaid Fraud Issues

■ Technical Eligibility (cont.)

□ Benefit Period

- Consecutive days beginning with the first day resident receives Medicare covered SNF services
- Ending when resident has remained at noncovered level of care in SNF for 60 consecutive days or is out of SNF and hospital for 60 consecutive days
 - Inpatient hospital stay considered covered level of care and will trigger new 60-day period

Medicare/Medicaid Fraud Issues

- Technical Eligibility (cont.)
 - Benefit Period (cont.)
 - New diagnosis does not trigger new benefit period
 - Benefit periods are not calendar based

Medicare/Medicaid Fraud Issues

- Clinical Eligibility
 - As a practical matter, the skilled services can only be provided in a SNF
 - The services provided must be for a condition for which the resident:
 - Was treated during the qualifying hospital stay, or
 - Arose while the resident was in the SNF for treatment of a condition for which the resident was previously treated in the hospital

Medicare/Medicaid Fraud Issues

- Clinical Eligibility (cont.)
 - A psychiatric admission to a hospital is acceptable as a 3 day hospital stay; however, the skilled service provided in the facility must be for the condition the resident was treated in the hospital
 - Need for and receipt of daily skilled services that must be reasonable, necessary and provided on a daily basis
 - Skilled nursing and rehabilitation services are those services furnished pursuant to physician orders

Medicare/Medicaid Fraud Issues

- Clinical Eligibility (cont.)
 - Skilled Nursing Services
 - Observation and assessment of a resident's condition
 - Teaching and training activities
 - Direct skilled nursing services to residents
 - IV injections
 - Nasogastric tube, gastrostomy, and jejunostomy feedings
 - Naso-pharyngeal and tracheotomy aspiration
 - Insertion, sterile irrigation, and replacement of catheters

Medicare/Medicaid Fraud Issues

■ Clinical Eligibility (cont.)

- Direct skilled nursing services to residents (cont.)
 - Application of dressings involving prescription medications and aseptic techniques
 - Treatment of decubitus ulcers, of a severity rated at Grade 4 or worse, or a widespread skin disorder

Medicare/Medicaid Fraud Issues

■ Clinical Eligibility (cont.)

- Direct skilled nursing services to residents (cont.)
 - Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the resident's progress
 - Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel

Medicare/Medicaid Fraud Issues

■ Clinical Eligibility (cont.)

- Direct skilled nursing services to residents (cont.)
 - Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
 - Care of a colostomy during the early postoperative period in the presence of associated complications (the need for skilled nursing care during this period must be justified and documented in the resident's clinical record)

Medicare/Medicaid Fraud Issues

■ Clinical Eligibility (cont.)

- Even though needed daily skilled services might be available on an outpatient or home basis, as a practical matter, the care can be furnished only in the skilled nursing facility (SNF) if home care would be ineffective because the resident would have insufficient assistance at home to reside there safely

Medicare/Medicaid Fraud Issues

■ Clinical Eligibility (cont.)

- While most beneficiaries requiring a SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a resident is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, or going on a ride for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF to receive required skilled care.

Medicare/Medicaid Fraud Issues

■ Hospice

- A Medicare beneficiary may elect the hospice benefit if he or she is entitled to Medicare Part A benefits and has a physician's certification of a prognosis of six or fewer months to live; the hospice assumes responsibility for the professional management of that resident's case and is paid by Medicare
- A facility may not bill Medicare for services related to the resident's terminal illness
 - Medicare will not pay two providers for the same service

Medicare/Medicaid Fraud Issues

- Hospice (cont.)
 - Payment (Medicare Part B) is made for services that are not related to the illness
 - When diagnosis for skilled nursing home benefit is not related to the diagnosis for hospice

Medicare/Medicaid Fraud Issues

- Critical documents
 - Provider Agreement
 - MDS
 - Cert/Recert
 - UB04
 - Therapy Logs
 - Clinical Documentation

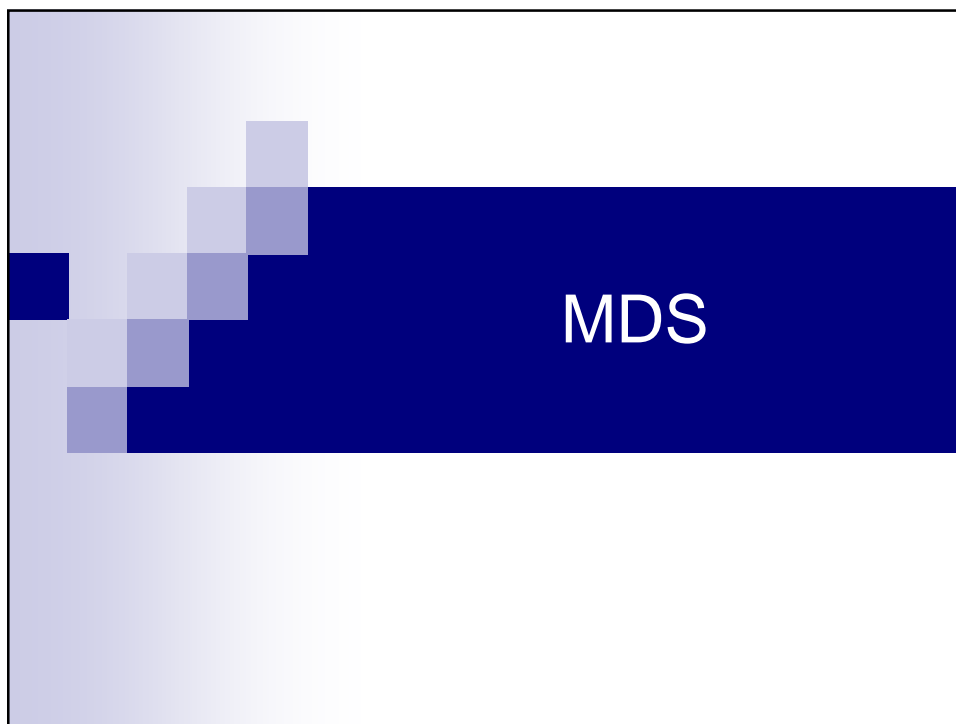
Provider Agreement



Medicare/Medicaid Fraud Issues

■ Provider Agreement

- I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider.
- The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
- I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.



Medicare/Medicaid Fraud Issues

Physician Certification and Re-Certification

- Services must be supervised or evaluated by a physician
- Specific form not required – the elements are
- Certification due at the time of admission or as soon thereafter as is reasonable and practicable
 - Certifies that the resident meets the existing SNF level of care

Medicare/Medicaid Fraud Issues

Physician Certification and Re-certification (cont.)

- Signed and dated by the physician
- Must contain medical necessity statement or the RUG category
- Cannot bill until certifications are complete and available
- Faxed processing is acceptable

Medicare/Medicaid Fraud Issues

Physician Certification and Re-certification (cont.)

- The first recertification is due on or before day 14 of the current stay (day one is the day of admission)
 - Must be signed and dated by the physician
 - Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) may sign re-certification
 - Only if NOT employed by the facility
 - Subject to state requirements
 - Physician Assistant (PA) may not sign regardless of employer

Medicare/Medicaid Fraud Issues

Physician Certification and Re-certification (cont.)

- Subsequent re-certifications are due within 30 days of the prior re-certification
 - Must be signed and dated by the physician
 - Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) may sign re-certification
 - Only if NOT employed by the facility
 - Subject to state requirements
 - Physician Assistant (PA) may not sign regardless of employer

Medicare/Medicaid Fraud Issues

Physician Certification and Re-certification (cont.)

- The re-certification required elements include:
 - Necessity for continued skilled care
 - Estimated length of stay
 - Post-discharge plan
- On rare occasions, it may be acceptable to complete a delayed certification or recertification
 - A sudden change in physician coverage
 - Lost or “missing” documents

Medicare/Medicaid Fraud Issues

Physician Certification and Re-certification (cont.)

- “Certifications, physician orders, plans of treatment and other documentation that are created after the Fiscal Intermediary (FI) requests records for post payment review will be considered fraudulent”

Initial Certification

Certification **MUST** be completed at the time of or prior to admission. There is no grace period allowed in obtaining the physician's certification statement signature. If certification is not completed timely any and all days prior to completing the certification statement will be denied and cannot be appealed.

Recertification

Recertifications must be completed on or before the 14th, 44th, and 74th stay days. Recertification **MUST** be completed by the designated deadlines. There is no grace period allowed in obtaining the physician's recertification statement. If recertification is not completed timely any and all days from the expiration of the prior certification/recertification to completing the current recertification statement will be denied and cannot be appealed.

Physician Orders

Physician Orders for Skilled Care

- In order to meet the criteria for skilled services for Medicare Part A:
 - The resident requires skilled nursing services or skilled rehabilitation services
 - The resident requires these skilled services on a daily basis
 - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only as an inpatient in an SNF
- The services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a resident's illness or injury

Physician Orders for Skilled Care

- The physician orders are required for specialized treatments and therapy services captured on the MDS
- The physician order must be signed for services captured on the MDS prior to submitting the UB04 claim for payment
- Medicare requires a legible identity for services provided/ordered
 - The method used to sign an order or other clinical record documentation for medical review purposes in determining coverage is not a relevant factor
 - An indication of a signature in some form needs to be present

Physician Orders for Skilled Care

- Providers using alternate signature methods (i.e., a signatures stamp) should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods
- The individual whose name is on the alternate signature method bears responsibility for the authenticity of the information being attested to

Therapy Issues

Medicare/Medicaid Fraud Issues

Skilled rehabilitation services

- Requires the skills of a licensed therapist to perform the evaluation and develop a plan
- Therapy services are required daily, at least five (5) times per week
- Skilled rehabilitation services must be:
 - Directly and specially related to an active written treatment plan designed by the physician after any needed consultation with a qualified therapist
 - Services must require a qualified therapist
 - Provided with the expectation that the condition will improve materially
 - Considered under accepted standards of medical practice and be specific to the treatment plan
 - Reasonable and necessary

Medicare/Medicaid Fraud Issues

Skilled rehabilitation services (cont.)

- Resident meets at least one (1) of the following criteria
 - Significant progress toward stated goals
 - Skilled therapy is still required – further assessment needed
 - Skilled therapy can only be provided on an inpatient basis as a practical matter
 - Skilled management of unskilled services is necessary

Documentation Requirements

Medicare/Medicaid Fraud Issues

- Medicare PPS documentation
 - The facility must maintain a complete and timely clinical record of the resident which includes diagnoses, medical history, physician's orders, and progress notes relating to all services received
 - Must substantiate the resident's need for Part A SNF-level services
 - Should reflect resident's response to the services
 - Should contribute to identification and communication of resident's problems, needs and strengths
 - Monitors the resident's condition on an ongoing basis
 - Is a record of treatments and services rendered

Medicare/Medicaid Fraud Issues


- Clinical record documentation is a matter of good clinical practice
- Detailed clinical record documentation provides data to assist in coding of the MDS
- CMS accepts the MDS as a primary data source; however,
 - Clinical documentation that clarifies, identifies and provides a clear picture of the resident's care needs and response to treatment is an accepted standard of practice, part of resident care, and care planning

Medicare/Medicaid Fraud Issues

- The SNF must be able to verify that the skilled services have been provided each day resident is receiving skilled services
- Documentation should be:
 - Precise
 - Legible
 - Contain information supporting skilled level of care
- Daily documentation may be completed using a checklist or narrative


Medicare/Medicaid Fraud Issues

- Interdisciplinary progress notes are beneficial to allow a reviewer or preparer of the MDS to gather all disciplinary documentation in one area of the clinical record
 - This also allows the interdisciplinary team to be more informed of the resident's status as they will be more inclined to read the progress notes when they are documenting
- Avoid duplication in documentation (i.e., detailed treatment logs)
- Some facilities have developed tools to collect data across shifts to assist with documentation through an assessment period
 - Tools are not mandated by CMS or by FIs



RACs

Recovery Audit Contractors

- 
- # RACs
- The Improper Medicare FFS Payments Report for November 2007 estimated that 3.9 percent of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules. This equates to \$10.8 billion in Medicare FFS overpayments and underpayments.

RACs

- ***Congress mandated the RAC program to detect and correct improper payments in the Medicare program.***
- Congress took action by passing legislation to enhance and support Medicare's current efforts in identifying and correcting improper payments in section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),
- Congress directed the Department of Health and Human Services (DHHS) to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program.
- In addition, in section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), Congress required DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010.

RACs

- Under the demonstration, the RACs are paid a contingency fee; that is, the RACs receive payment based on the amount of the improper payments they correct for both overpayments and underpayments. Each RAC's contingency fee is established during contract negotiations with CMS and, as such, the contingency fee varies for each RAC. Information on the contingency fee is considered proprietary and not disclosable.

RACs

- CMS website re: RACs

- <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf>

RAC Program Mission

- The RACs detect and correct past improper payments so that CMS and Medicare Administrative Contractors (MACs) can implement actions that will prevent future improper payments.
 - Providers can avoid submitting claims that do not comply with Medicare rules
 - CMS can lower its error rate
 - Taxpayers and future Medicare recipients are protected

RACs

- The RAC Review Process
 - RACs review claims on a post-payment basis
 - RACs use the same Medicare policies as Carriers, FIs and MACs: NCDs, LCDs and CMS Manuals
 - Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
 - RACs will not be able to review claims paid prior to October 1, 2007
 - RACs will be able to look back three years from the date the claim was paid
 - RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician CMD

RACs

- Collection Process
 - Same as for Carrier, FI and MAC identified overpayments (except the demand letter comes from the RAC)
 - Carriers, FIs and MACs issue Remittance Advice
 - Remark Code N432: Adjustment Based on Recovery Audit
 - Carrier/FI/MAC recoups by offset unless provider has submitted a check or a valid appeal

When RAC identifies an improper payment

- What is different?
 - Demand letter is issued by the RAC
 - RAC will offer an opportunity for the provider to discuss the improper payment determination with the RAC (this is outside the normal appeal process)
 - Issues reviewed by the RAC will be approved by CMS prior to widespread review
 - Approved issues will be posted to a RAC website before widespread review

RACs

- If you agree with the RAC's determination:
 - Pay by check
 - Allow recoupment from future payments
 - Request or apply for extended payment plan
 - Appeal
- Appeal Timeframes
 - <http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/Appeal%20processflowchartAB.pdf>
 - <http://www.cms.gov/MLNProducts/downloads/MedicareAppeals%20process.pdf>

RAC Subcontractor Information

- **Region A: Diversified Collection Services (DCS)**
- Subcontractors: PRG Shultz, iHealth Technologies and Strategic Health Solutions
- **Region B: CGI**
- Subcontractor: PRG Schultz
- **Region C: Connolly, Inc.**
- Subcontractor: Viant, Inc.
- **Region D: HDI**
- Subcontractor: PRG Schultz

RAC Contact Information

- Region A: Diversified Collection Services
www.dcsrac.com (website)
info@dcsrac.com (email)
1-866-201-0580 (phone)

RACs

- **STATE:**Pennsylvania **SPA**
- **Status:**SPA Submitted
- **Date SPA received:**12/23/2010
- **Exception Requested:**No
- **RAC Fee Structure:**Contingency Fee

RACs

- **Minimize Provider Burden**
 - Limit the RAC “look back period” to three years
 - Maximum look back date is October 1, 2007
 - RACs will accept imaged medical records on CD/DVD (CMS requirements coming soon)
 - Limit the number of medical record requests

RACs

- Ensure Accuracy
 - Each RAC employs:
 - Certified coders
 - Registered Nurses
 - Therapists
 - A physician CMD
 - CMS' New Issue Review Board provides greater oversight
 - RAC Validation Contractor provides annual accuracy scores for each RAC
 - If a RAC loses at any level of appeal, the RAC must return its contingency fee

RACs

- Know where previous improper payments have been found
 - Look to see what improper payments were found by the RACs:
 - Demonstration findings: www.cms.hhs.gov/rac
 - Permanent RAC findings: will be listed on the RACs' websites
 - Look to see what improper payments have been found in OIG and CERT reports
 - OIG reports: www.oig.hhs.gov/reports.html
- CERT reports: www.cms.hhs.gov/cert

Elder Justice Act

- Part of the Patient Protection and Affordable Care Act signed in to law on 3/23/10

Elder Justice Act

- Elder justice activities
 - Prevent, detect, intervene in, and prosecute elder abuse, neglect, and exploitation
 - Protects elders with diminished capacity while maximizing their autonomy

Elder Justice Act

- Provided \$100 million/year for four years to support Adult Protective Services programs in the states
 - Improve and train state ombudsman and surveyors in investigations of allegations of abuse, neglect and exploitation
 - Incentives for training and employment of direct care workers

Elder Justice Act

- Mandatory reporting of crimes occurring in long term care facilities
- Every individual employed by or associated with a long-term care facility as an owner, operator, employee, manager, agency, or contractor is required to report any reasonable suspicion of a crime against facility residents to the Secretary of HHS and to law enforcement officials

Elder Justice Act

- If the event that caused the suspicion results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion.
- If the event does not result in bodily injury, the individual is required to report no later than 24 hours after forming the suspicion.

Elder Justice Act

- The law imposes stiff penalties for failure to report: up to \$200,000 in civil money penalties or, when lack of reporting results in exacerbation of harm to the victim, up to \$300,000.
- In both cases, the Secretary has the option to exclude the non-reporting individual from participating in federal health care programs.

Elder Justice Act

- \$18 million in grants to develop stationary and mobile forensic centers to develop expertise in elder abuse, neglect, and exploitation
- Funds used to
 - develop forensic markers and methodologies to determine whether abuse, neglect, or exploitation or a crime has occurred;
 - develop forensic expertise regarding elder abuse, neglect, and exploitation to provide medical and forensic evaluation, therapeutic intervention, and victim support and advocacy;
 - and develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence

Patient Protection and Affordability Act

- Removes barbiturates and benzodiazepines from Medicaid's excludable drug list in 2014
- Allows states to cover community-based attendant services if beneficiary would otherwise require hospital or nursing home level care – 10/2011

Patient Protection and Affordability Act

- Prohibits Medicaid payment for services related to a “health care-acquired” condition. CMS will develop a list of the conditions based on current Medicare and state practices.

Patient Protection and Affordability Act

- Nursing Home Transparency
 - Requires disclosure of ownership information, including a description of the governing body and organizational structure.
 - Requires nursing facilities to implement compliance and ethics programs for a facility’s employees and agents.
 - Requires CMS to add information on standardized staffing data, a summary of substantiated complaints, and the number of adjudicated criminal violations by a facility or its employees to Nursing Home Compare.

Patient Protection and Affordability Act

- Nursing Home Transparency (cont.)
 - Requires CMS to develop a mechanism for nursing facilities to report staffing information in a uniform format based on payroll data, also reflecting use of contract or agency staff.
 - Requires Government Accountability Office to study the Five-Star Nursing Home Quality Rating System.
 - Allows CMS to discount civil monetary penalties by 50 percent for self-reported deficiencies corrected within ten days.

Patient Protection and Affordability Act

- Nursing Home Transparency (cont.)
 - Requires CMS to establish a demonstration project to develop an independent monitor program to maintain oversight of interstate and large intrastate nursing home chains.
 - Requires training on dementia care and abuse prevention for nursing home staff.
 - Requires CMS to establish a nation-wide program of criminal background checks for employees of long-term care providers who have direct access to patients. Program to be based on previously-authorized and ongoing demonstration projects.

Patient Protection and Affordability Act

- Waste/Fraud/Abuse
 - Requires CMS to develop procedures for screening health care providers participating in Medicare and Medicaid that at minimum would include licensure checks, but which could also include criminal background checks, fingerprinting, multi-state database inquiries, and random or unannounced site visits

Patient Protection and Affordability Act

- Waste/Fraud/Abuse (cont.)
 - Maximum period for submission of Medicare claims reduced to twelve months.
 - Expands the recovery audit contractor (RAC) program to state Medicaid programs and to Medicare Parts C and D.

Preventable Serious Adverse Events

- Published as proposed in PA Bulletin
10/16/2010
 - <http://www.pabulletin.com/secure/data/vol40/40-42/1975.html>

Preventable Serious Adverse Events

- Health care providers, including nursing facilities, may not knowingly seek payment from a health payor or patient
 - (1) for a preventable serious adverse event (PSAE); or
 - (2) for any services required to correct or treat the problem created by a PSAE

Preventable Serious Adverse Events

- Requires a health care provider that unknowingly receives payment for services associated with a PSAE or for the services to correct the PSAE to immediately notify the health payor or patient and refund the payment within 30 days of discovery or receipt of payment, whichever is later.

Preventable Serious Adverse Events (Proposed)

- **Criteria**
 1. The event was preventable. To be preventable, the event could have been anticipated and prepared for, but, nonetheless, occurred because of an error or other system failure; and
 2. The event was serious. The event is serious if the event subsequently results in death or loss of body part, disfigurement, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a nursing facility; and
 3. The event was within the control of the nursing facility. Control means that the nursing facility had the power to avoid the error or other system failure; and
 4. The event occurred as a result of an error or other system failure within the nursing facility.

Preventable Serious Adverse Event (Proposed)

- 1. Surgical Events
 - A. Surgery performed on the wrong body part
 - B. Wrong surgical procedure performed on a resident
 - C. Surgery performed on the wrong resident
 - D. Unintended retention of a foreign object in a resident after surgery or other procedure

Preventable Serious Adverse Events (Proposed)

- 2. Product or Device Events
 - A. An event associated with the use of contaminated drugs, devices or biologics provided by the nursing facility
 - B. An event associated with the use or function of a device in resident care in which the device is used or functions other than as intended
 - C. An intravascular air embolism that occurs while being cared for in a nursing facility
- 3. Resident Protection Events
 - A. Resident suicide or attempted suicide
 - B. Resident elopement (disappearance for more than four hours)

Preventable Serious Adverse Events (Proposed)

- 4. Care Management Events
 - A. A medication error (such as, errors involving the wrong drug, wrong dose, wrong resident, wrong time, wrong rate, wrong preparation, or wrong route of administration)
 - B. Severe allergic reaction
 - C. A hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
 - D. Stage 3 or 4 pressure ulcers acquired after admission to the nursing facility
 - E. Catheter-associated Urinary Tract Infection
 - F. An event related to spinal manipulative therapy
 - G. Vascular catheter-associated infection
 - H. An event related to hyper- or hypoglycemia (Diabetic ketoacidosis, Nonketotic hyperosmolar coma, Diabetic coma, Hypoglycemic coma) the onset of which occurs while the resident is being cared for in a nursing facility.

Preventable Serious Adverse Events (Proposed)

- 5. Environmental Events
 - A. A burn incurred from any source while being cared for in a nursing facility
 - B. An event related to a fall (fractures/dislocations/intracranial injuries/crush injuries/burns) while being cared for in a nursing facility
 - C. An electric shock while being cared for in a nursing facility
 - D. Any incident in which a line designated for oxygen or other gas to be delivered to a resident contains the wrong gas or is contaminated by toxic substances
 - E. An event associated with the use of restraints or bedrails while being cared for in a nursing facility.

Preventable Serious Adverse Events (Proposed)

- 6. Criminal Events and Unlawful Activities
- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- B. Abduction of a resident
- C. Sexual assault on a resident
- D. A physical assault (that is battery).

Preventable Serious Adverse Events (proposed)

- Rate Reduction Template
- http://www.portal.state.pa.us/portal/server.pt/document/930019/psae_rate_reduction_template_nonpublic_nursing_facilities_xls



Skilled Healthcare Group Reaches Settlement September 8, 2010

*After losing its bid for a mistrial based on alleged juror misconduct, [Skilled Healthcare](#) reached an agreement yesterday to settle the case against it which involved allegations of understaffing at 22 California skilled nursing facilities that resulted in a **\$677 million jury verdict.***