



HealthPartners/GHI

Subject: Never Events	Attachments <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Key words: Never Events, Minnesota Adverse Health Care Events Reporting Act	Number GHI - BP-AN001
Category Business Practices (BP)	Effective Date 01/07/05
Manual Provider Information-Administrative Manual	Last Review Date 05/01/06
Issued By Medical Management	Next Review Date 05/01/07
Applicable This policy applies to all facilities as defined by the Minnesota Adverse Health Care Events Reporting Act.	Origination Date 01/07/05
	Retired Date
Review Responsibility Medical Management and Contracted Care Divisions	Contact Brenda Thommen

- I. **PURPOSE** The purpose of this policy is to document our providers' responsibility in accordance with the Minnesota Adverse Health Care Events Reporting Act and HealthPartners review process for notifications of Never Events that were billed to a member or HealthPartners.
- II. **POLICY** HealthPartners will not reimburse for services associated with a Never Event or permit providers to bill members. If the provider bills HealthPartners or the member, the attached Quality Case Review Form must be submitted to HealthPartners. It is the policy of HealthPartners to initiate a quality case review for all Never Events reported to HealthPartners.
- III. **PROCEDURE(S)**
HealthPartners Responsibility:
 1. HealthPartners will initiate a quality case review for notifications of Never Events that were billed to a member or HealthPartners. All quality case review information will be confidential in accordance with MN Statute 145.64.
 2. HealthPartners will review all Never Event notifications and make a case specific determination regarding any HealthPartners or member liability.

Provider Responsibility:

 1. Providers will maintain policies and procedures that address the Never Events. HealthPartners expects that providers will act in compliance with the Minnesota Adverse Health Care Events Reporting Act.
 2. Providers will be expected to report to HealthPartners the details associated with any Never Event for which the member or HealthPartners was billed. The Never Event notification will include:
member name, member number, date of services and occurrence, attending physicians and description of the event.
 3. If a Never Event occurs, the provider will not seek reimbursement from the HealthPartners member unless member liability has been determined by HealthPartners.
- IV. **DEFINITIONS** Minnesota Law (Minnesota Adverse Health Care Events Reporting Act – Minn. Stat. §§ 144.706–144.7069) defines
27 Never Events as listed below:
See the statute for the full text of each event's definition.

SURGICAL EVENTS

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. Retention of a foreign object in a patient after surgery or other procedure
5. Death during or immediately after surgery of a normal, healthy patient

PRODUCT OR DEVICE EVENTS

6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device 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 facility

PATIENT PROTECTION EVENTS

9. An infant discharged to the wrong person
10. Patient death or serious disability associated with patient disappearance for more than four hours
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility

CARE MANAGEMENT EVENTS

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the 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 in a low-risk pregnancy while being cared for in a facility
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a facility
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life
17. Stage 3 or 4 ulcers acquired after admission to a facility
18. Patient death or serious disability due to spinal manipulative therapy

ENVIRONMENTAL EVENTS

19. Patient death or serious disability associated with an electric shock while being cared for in a facility
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
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility
22. Patient death associated with a fall while being cared for in a facility
23. Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility

CRIMINAL EVENTS

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
25. Abduction of a patient of any age;
26. Sexual assault on a patient within or on the grounds of a facility
27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility

V. **ATTACHMENTS** Quality Case Review-Never Event (pathway: Provider Home Page/For Providers/Administrative Policies)

VI. **OTHER RESOURCES**

Other Minnesota Law (Minnesota Adverse Health Care Events Reporting Act – Minn. Stat. §§ 144.706–144.7069)

VII. **APPROVALS**

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