Alerts and Updates

NEW JERSEY GOVERNOR SIGNS LANDMARK HOSPITAL LAW

September 14, 2009

On August 31, 2009, New Jersey Gov. Jon Corzine signed into law an act requiring hospitals to publicly report 14 serious medical errors. One of the first laws of its kind in the United States, this legislation also bars hospitals in New Jersey from seeking reimbursement for costs associated with the following "never events" for which Medicare does not allow payment: surgery on the wrong side, body part or person; the wrong surgery; air embolism; transfusion reaction; and a foreign object left inside a patient during a procedure.

Commencing in November 2009, New Jersey's annual hospital performance report—published by the state Department of Health and Senior Services—will include data on the number and rate of the following serious indicators of patient safety in each of the hospitals in the state:

1. Foreign body left during procedure;
2. Iatrogenic pneumothorax;
3. Postoperative hip fracture;
4. Postoperative hemorrhage or hematoma;
5. Postoperative deep vein thrombosis or pulmonary embolism;
6. Postoperative sepsis;
7. Postoperative wound dehiscence;
8. Accidental puncture or laceration;
9. Transfusion reaction;
10. Birth trauma;
11. Obstetric trauma-vaginal delivery with instrument;
12. Obstetric trauma-vaginal delivery without instrument;
13. Air embolism; and
14. Surgery on wrong side, wrong body part or wrong person, or wrong surgery performed on a patient.

Currently, the New Jersey Department of Health and Senior Services publishes a hospital performance report each year on hospital-specific treatment of heart attacks, pneumonia and heart failure, and prevention of surgical infections. The state

health department also issues a report on indicators of quality of inpatient care used to measure the performance of the state's hospitals in treating common medical conditions. According to New Jersey Commissioner of Health and Senior Services Heather Howard, "We know that public reporting of hospital performance improves quality and promotes excellence in patient safety—as we have seen with dramatic decreases in cardiac surgery deaths." Publicizing more patient-safety data may assist patients and their families to make informed decisions about their care and the hospitals they choose.

An interesting aspect of the new law is likely to be the determination of whether a cost or expense is associated with any of the "never events" for which payment will be denied by third parties. This factor is anticipated to generate further debate, and many other states are likely to undertake similar efforts to publicize and restrict reimbursement associated with medical errors in hospitals.

For Further Information

If you have any questions about this Alert or would like more information, please contact Katherine Benesch, any of the attorneys in our Health Law Practice Group or the attorney in the firm with whom you are regularly in contact.