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Medicare: Uncle Sam's New Scrutiny
Medicare says it will stop paying hospitals to fix their 'mistakes.' Is your practice next?
By Barbara A. Gabriel

Superman was the victim of a medical mistake.

Sound far-fetched? The Man of Steel survived a spinal cord injury so severe that it left him paralyzed from the neck down for the last nine years of his life — years that he spent actively defying his doctors' dire predictions by living an active life and advocating for medical research.

Ultimately — under the care of his devoted wife and the best doctors money could buy — Christopher Reeve died from a pressure ulcer, more commonly known as a bed sore. The infections that can result from bed sores are not uncommon. Obese patients and victims of paralysis are often confined to the same positions for extended periods of time, and pressure ulcers can develop even under the best medical care.

But under a new Medicare rule that will take effect October 1, 2008, Reeve's death would be attributable to a medical error. And Medicare has announced that it will no longer reimburse hospitals for remedying a specific list of events — including pressure ulcers — that CMS deems preventable.

So what does this mean for you?

Pressure ulcers are on a list of 28 medical errors, or "never events," defined by the National Quality Forum (NQF) in 1992 as preventable medical mistakes that the forum says should never occur in a hospital (see "Never Events" text box). In addition to pressure ulcers, these events include medication errors, falls, and much more egregious mistakes such as wrong-site surgeries.

'Never Events' as Defined by the National Quality Forum

Need More Help?
Ask an Expert.

In Summary

Later this year, Medicare will no longer reimburse hospitals for the costs incurred to redress a list of medical mistakes called "never events." That list is expected to only grow longer with time. Will physicians soon be held to the same rules? Here's what you need to know:

- The current list of medical mistakes includes errors that rarely occur in the majority of physician offices.
- Physicians should take particular care to make comprehensive notes when hospitalizing patients, including checking for preexisting conditions that are on Medicare's list.
- Physicians' hospital credentials could be at risk if they are repeatedly connected to medical errors while

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1. Unintended retention of a foreign object in a patient after surgery or other procedure.

2. Patient death or serious disability associated with patient elopement (disappearance).

3. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).

4. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.

5. Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility.

6. Patient death or serious disability associated with a fall while being cared for in a healthcare facility.

7. Surgery performed on the wrong body part.

8. Surgery performed on the wrong patient.

9. Wrong surgical procedure performed on a patient.

10. Intraoperative or immediately post-operative death in an ASA Class I patient.

11. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.

12. 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.

13. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

14. Infant discharged to the wrong person.

15. Patient suicide, or attempted suicide, resulting in serious disability, while being cared for in a healthcare facility.

16. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility.

17. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient

tending to hospitalized patients.

- Several major commercial payers have announced their own plans to stop reimbursing medical mistakes that occur in hospitals.

Read More About It

For more information on reimbursement issues, the law, and how to protect yourself, check out the following:

- You've made a medical mistake, and you know it. Are you opening yourself up to a lawsuit if you apologize? Find out by reading, "Apology Accepted."

- To learn how to make the most out of Medicare read, "Thriving Under Medicare."

- Find out how to stay on top of Medicare's ever-changing policies. "Know Your Medicare Carrier" has lots of pertinent information and tips.

is being cared for in a healthcare facility.

18. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.

19. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.

20. Patient death or serious disability due to spinal manipulative therapy.

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 healthcare facility.

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

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.

25. Abduction of a patient of any age.

26. Sexual assault on a patient within or on the grounds of the healthcare facility.

27. 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 the healthcare facility.

28. Artificial insemination with the wrong donor sperm or donor egg.

In August 2007, Medicare announced that, starting October 2008, it will no longer reimburse the treatment hospitals must provide to redress eight medical errors, a list likely to lengthen in the future (see “Nonreimbursable” text box). In fact, CMS has already announced its plan to add ventilator-associated pneumonia and deep vein thrombosis to its list in fiscal year 2009.

Some of the additional NQF-specified never events that experts predict Medicare will add to its list *are* no-brainers, and many hospitals do not charge for them anyway. Operating on the wrong patient or wrong side of the body, indeed, should never happen. But there are several events on the list that hospitals consider unpreventable in some instances. For example, many hospitals maintain that pressure ulcers, patient falls, and vascular catheter-associated infections (all included on Medicare’s initial list) are

inevitable
in some cases and in others totally outside of physicians' control.

When announcing its decision, Medicare stated in a press release: "While the exact number of never events is not known, they result in many deaths and additional healthcare costs. In 1999, the Institute of Medicine estimated that as many as 98,000 deaths a year were attributable to medical errors, and recommended that error-related deaths be decreased by 50 percent over five years."

Medicare's Nonreimbursable Never Events

1. Unintended retention of a foreign object in a patient after surgery or other procedure.

2. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

3. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.

4. Catheter-associated urinary tract infections.

5. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.

6. Vascular catheter-associated infections.

7. Surgical site infection – Mediastinitis after coronary artery bypass graft (CABG) surgery.

8. Patient death or serious disability associated with a fall while being cared for in a healthcare facility.

The Bush administration has stated that this new policy is a big step toward encouraging hospitals to enhance their quality-control measures and cut down on preventable injuries and deaths.

But this rule only applies to *hospital* reimbursement. What does that have to do with physician practices?

Time to worry?

"So goes Medicare, so goes the healthcare system," says David Nash, chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia. "You can run, but you can't hide; there's no question about that in my mind."

Indeed. Since Medicare's announcement last August, Aetna, WellPoint, UnitedHealth Group, Cigna, and Blue Cross/Blue Shield have either already implemented similar policies, are testing them in

specific markets, or are considering doing so.

Private-practice physicians following these developments are fearful that these new rules will either affect them in their capacity of treating their hospitalized patients and/or trickle down into the outpatient environment. Physician bloggers took to their keyboards immediately after the news broke.

“This is extraordinarily detrimental for physicians,” wrote one doctor. “It will increase malpractice premiums enormously. Bed sores, particularly heel ulcers, in patients with diabetic vascular disease, are nearly impossible to prevent in patients with strokes.”

“This ‘remedy’ appears to be designed to penalize bad results, not real mistakes,” wrote another physician. “Bedsores and infections are sometimes unavoidable, even with the best care. It is a hallmark of some diseases. This is a very ill-advised means to cut costs; it is actually a cost shift from CMS to the hospital and, eventually, physician.”

Others were more emphatic.

“Not paying for a blood clot following surgery? Are you kidding?” questioned a third physician. “I’ve had patients on heparin and they throw a clot anyway. Patients need to take some responsibility too. Some of them are multisystem train wrecks.”

Is such outrage well-founded?

Well, Armageddon, if it does arrive, is still a ways off, says Robert Field, chair of the Department of Health Policy and Public Health at the University of Sciences in Philadelphia.

“The never events that are being discussed are pretty much all inpatient related — incorrect surgeries, incorrect drugs, incorrect blood infusions … These are typically not going to happen in outpatient settings, particularly not in physician offices,” says Field, although he does say that, in time, the rule could conceivably apply to surgical ambulatory or diagnostic clinics.

“What I *do* think could trickle down is the general mindset of being more aggressive in dealing with errors and quality lapses,” says Field. Noting that significant errors do not typically occur in routine physician practices, Field does link the never-event initiative to current pay-for-performance programs. Admitting that his view is “speculative,” Field says it’s conceivable that the financial awards and penalties currently made available to physicians by Medicare and commercial payers for meeting prescribed quality standards could grow significantly in scope: “So if a physician takes an action that isn’t a serious action, but it doesn’t meet the guideline that the payer believes should be followed, they could become aggressive in either not paying it at all, or paying less for it.”

Nash agrees. He also sees the never-event program as Medicare taking one more step toward expanding its pay-for-performance agenda. “The Physicians Quality Reporting Initiative (PQRI), which right now is voluntary but will become compulsory later this year,

involves ambulatory quality measures of what goes on in the office," says Nash. He perceives the PQRI program on the ambulatory side to be analogous to the never-event policy on the hospital side: "It's all part of the same philosophy, which is to change Medicare into a savvy shopper for healthcare."

Alice Gosfield, past president of the American Health Lawyers Association and president of Alice G. Gosfield & Associates, LLP, believes that Medicare's new rule is a much-needed step to force physicians to pay attention to the quality of care their patients are receiving when they are hospitalized.

"There is no reason whatsoever to believe that this will not be extended to physicians," says Gosfield. "Why should a physician be paid when he operates on the wrong side of the body? There's absolutely no justification for it."

Although under the never-event rule physicians may still bill for their services when a mistake on Medicare's list occurs in the hospital, Gosfield says those days are numbered. "I think at some point that will change," she says. "There's going to be more and more emphasis on shared clinical responsibility for patients — that you should pay attention to where you are referring to and who you're taking referrals from.

"The message of the never events is that it's time for physicians to stand up and take responsibility to make sure the hospitals in which they practice are safe, or find other hospitals."

Proactive protection

Experts agree that another way in which private-practice physicians could be affected by the never-event rule is its potential to influence their credentialing privileges within specific hospitals.

"The never events are eventually going to come around to the physician in that hospitals will be more vigilant about physicians who are connected to these events," says Nash. "Eventually, hospitals that are smart will link these events back through the credentialing process to individual doctors. I don't think it's an immediate risk today, but clearly, in another year, I think it's going to be very, very important that physicians recognize how these events could be traced back to them. … Even private-practice doctors, via the credentialing process could be identified as difficult physicians."

Monica Berry, director of patient safety and risk management at the Loyola University Health System in Chicago and past president of the American Society for Health Risk Management, agrees that private-practice physicians will need to keep a keener eye on their hospitalized patients lest they be connected with a never event.

To protect themselves, Berry recommends that doctors pay close attention to documenting their patients' health histories and presenting illnesses. "My recommendation is to document what the status of the patient is, and make sure that their history is the best that you can do," says Berry.

Accurate charting and documentation are key, agrees Nash. After all, it's not inconceivable that a patient you admit to a hospital already has a pressure ulcer or an infection that remains undetected until that patient is hospitalized. So full examinations are crucial. Detailed patient notes can also inform hospital staff that a patient's immune system is compromised, making her more susceptible to infections, or enlist staff to encourage an obese patient to walk around lest pressure ulcers form.

"Here is where very, very good charting and documentation protects everybody," says Nash. "I think the take-home message here is to make sure that your office records reflect the office admission record, and that you are as detailed and as comprehensive as possible."

The impact on malpractice

Of course, any time a major change in Medicare reimbursement is announced, the specter of increased malpractice claims and higher premiums arises.

Gosfield speculates that as the kinks are smoothed out in the new never-event rule, litigation will inevitably occur. "Any time risk expands and your risk-protecting techniques are not commensurate with the exposure, then your risk goes up," she says. "Do I think premiums will go up immediately? No. … I don't think we're there yet."

Berry agrees that litigation will arise in cases in which hospitals attempt to prove that an adverse event should be reimbursed, but she also says she doesn't expect that to happen any time soon. However, malpractice carriers will start looking into the new risks associated with this rule, says Berry: "When you look at how much money could be involved here, it's a significant chunk of change."

"There are always litigation risks," adds Nash. "That goes without saying. There are going to be all kinds of precedent-setting cases that are going to come from this, but it's way too early to tell right now."

To nip such risks in the bud, the Washington State Medical Association took the proactive step in January of pledging not to bill payers or patients for its own list of 28 never events, most of them taken from NQF's list. Brian Wicks, president of the association and the owner and founder of a nine-physician multispecialty practice in Washington, says the decision not to bill patients for the listed events had nothing to do with Medicare's impending rule.

Wicks says that when the association looked at the number of medical mistakes occurring in hospitals across the state, they were "extremely" small. "Over the past year, the state had 619,000 admissions and 193 never events, and most of those were bed sores," says Wicks, "so it wasn't like there was a whole lot of never-event activity going on that this agreement was going to eliminate. Our goal is to bring these events to peoples' attention so we can set into place the systems that will potentially reduce these never events

to zero. … If you apply appropriate protocols for handling central lines, for handling patients on ventilators, you can dramatically decrease the incidence of these infections."

While you will find bed sores on the association's list, Wicks says that sometimes they are simply inevitable. "If you have people who are extremely ill, elderly, and in the ICU, there's a limited amount of stuff that you can do to prevent bed sores," says Wicks. "So we had a lot of discussion among our members about wording the language such that there would be some ability to do a root-cause analysis to find out if an event was indeed preventable."

Wicks says he expects that physicians and hospitals will now more thoroughly screen patients before admission, examining them for bed sores, checking for urinary tract infections, and screening for pneumonia. "If you identify those items before the patient is admitted, then it's not legitimate for Medicare to say it was a hospital-acquired infection," he says. "I think you're going to find people saying, 'Listen Medicare, we're taking care of extremely sick people with suppressed immune systems, and we can't prevent ventilator-acquired pneumonia in everybody."

The Washington Ambulatory Surgery Center Association joined the Washington State Medical Association in its agreement not to bill for the same list of never events. The association represents freestanding ambulatory surgery centers that include physician-owned practices ranging from multispecialty to single-specialty groups. Terry Hawes, the association's president, maintains that the 28-item list of never events they've adopted so rarely occur in ambulatory centers that the decision not to bill for them was not a difficult one. "These events happen so infrequently … that not billing a patient once a year, if that, is not going to cause the downfall of that center," she says.

A Pandora's box

Gosfield says the new rule is a long-overdue wake-up call for physicians. "Clearly, the surgical specialties are the ones at greatest risk, and also specialties that are involved with patients in the ICU, where complex things happen," she says. "Doctors have to ask themselves about the hospitals they admit their patients to: 'How many hearses are pulling up to the back door?' 'How many people are discharged with life-changing tragedies?' I think it speaks to the intensified, reinvigorated responsibility of the physicians in the hospital to step up."

For her part, Berry finds the new rule troubling. "I understand the need for organizations to take responsibility for some of the patient events," she says. "But some of what happens is not a result of negligence. These events simply happen."

In particular, Berry worries that hospital rehab units, and in time, physician-owned private rehab practices are especially at risk. As part of patients' rehab, they have to relearn how to walk and thus are unstable, she points out. "Does that mean that the organization has to take a financial hit if a patient in the course of his or her rehab takes a tumble and fractures a hip? … I'm just not sure that the

government in the enforcement of this rule is going to be as knowledgeable as it needs to be in understanding those hospital-acquired injuries."

Field perceives the new rule to be the opening round in the government's effort to "get serious" about medical errors. Calling egregious errors, such as wrong-site surgery, "low-hanging fruit," he foresees Medicare's list expanding over time. "I think it will likely get the ball rolling, because we do now have almost ten years of discussion and analysis and debate about what to do about the problem of medical errors. … This list of medical mistakes will increase. It's sort of a matter of getting the kinks out over time."

Clearly, some doctors are worried that CMS is embarking on an intentionally slippery slope.

Another physician blogger recently posted that the new rule is a backdoor method to reduce costs as much as possible. "CMS assumes that it can force hospitals to force physicians to start to either change processes or assume some risk (certainly not true for most hospitals and physicians at this point) … We should expect to see more of the same type of cuts very soon, and yes, the next round of cuts will hit physicians' pocketbooks."

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