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Bracing For The Surge In Reimbursement Disputes

Law 360, New York (December 11, 2008) — Medicare will no longer reimburse for expenses resulting from "hospital acquired" medical complications as common as catheter or surgery-site infections.

The Medicare new rules, effective since October 1, 2008, are expected to give rise to a surge of litigation between hospitals, patients, physicians and drug and medical industry business.

In 2007, as required by the Deficit Reduction Act (DRA) (2005), the Centers for Medicare and Medicaid (CMS) identified medical errors, "never events", that it deemed to be reasonably preventable, with the goal of halting payments to hospitals servicing patients with these conditions.

Specifically, section 5001c of the DRA authorized the secretary of the Department of Health and Human Services to select conditions that 1) are high cost, high volume, or both; (2) are identified through coding as complicating conditions, or major complicating conditions, that when present as a secondary diagnoses on claims, result in higher cost; and (3) are reasonably preventable through application of evidence based guidelines.

After October 1, 2007, hospitals were required to report after discharges whether the diagnoses for selected conditions were present at the time of admission.

As of October 1 of this year, if the condition is not present upon admission, but is acquired during the hospital stay, Medicare will no longer pay the additional cost of hospitalization, nor will the hospital be allowed to require that the patient be responsible for the cost.

CMS identified the following as conditions for which it would cease payments: foreign objects retained after surgery; air embolism; blood incompatibility, pressure ulcer stages III &IV; falls and trauma; catheter-associated urinary tract infections; vascular catheter associated infections; manifestations of poor glycemic control; surgical site infection, mediastinitis, following coronary artery bypass graft; surgical site infection following certain orthopedic procedures; surgical site infection following bariatric surgery for obesity; and deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

CMS based its decision to halt payments for "never events" on its belief that such a step was necessary in order to improve the quality of care in hospitals and limit medical errors that result in serious consequences to patients.

Kerry Weems, acting administrator for CMS, in a press release dated July 31, 2008 and printed on their Web page at www.cms.hhs.gov, said that "never events cause serious injury or death to the beneficiaries and result in unnecessary cost to Medicare and Medicaid due to the need to treat the

consequences for errors. CMS is committed to protecting Medicare and Medicaid patients from the consequences of these errors."

According to a 1999 Institute of Medicine report, "never events" account for up to 98,000 deaths a year at a cost in excess of $37 billion dollars:

"Never events were addressed by the National Quality Forum, which by 2006 had compiled a list of 28 medical errors that are clearly identifiable, preventable and serious in their consequences for patients. CMS rule overlaps some of the events identified by the National Quality Forum. Aon Corp, in a 2007 study related that 'never events' accounted for 12.2 percent of total legal liability cost insured by healthcare facilities."

The "never events" identified by the Aon research are included on the CMS list of conditions.

Medicare's decision not to pay for certain "never events" has spread beyond its boundaries and has had an impact on the private and public insurance community influencing them to address this issue.

Several of the largest private insurers in America, such as Blue Cross Blue Shield, Cigna, WellPoint and Aetna, have declared that they will not pay for identified "never events." As many as 20 states have joined this effort and identified as many as 28 "never events" as non-reimbursable.

Reaction to Medicare's rule has been mixed. Public and private insurance groups, as previously indicated, are responding by adopting major aspects of Medicare's rule.

Patient rights groups laud the rule as being a step in the right direction to address patient safety, but they have reservations about the rule and have raised concerns that the implementation of the rule, may result in reducing the availability of medical care to Medicare eligible recipients by cutting payments for services to hospitals and physicians.

Some question Medicare's motivation for adopting the rule; they fear it might be another way for Medicare to cut its cost and not really a concern for patient safety. They are especially leery of private insurance group's motivation in this regard.

The consensus view appears to be that while hospitals should be held accountable for patient safety, it is also necessary that both Medicare and private insurers be held accountable and not be allowed to use "never events" as a measure to lessen cost.

Doctors in the private sector have raised concern that Medicare's rule will have a negative impact on their ability to treat their hospitalized patients. They are particularly concerned about how it will impact their malpractice insurance premiums.

Many private physicians view the rule as a cost shifting device. They believe it serves to shift cost from CMS to the hospital and eventually to the physician. Some see the rule expanding to impact surgical and ambulatory or diagnostic clinics. Most feel such expansion would negatively impact the healthcare community.

Early evidence suggests that the implementation of Medicare's rule on "never events" will have an immediate impact on the healthcare system's delivery of services to patients.

The American Association of Hospitals suggests that the rules' focus on post admission conditions will encourage unnecessary and expensive pre-admission testing by hospitals.

Hospitals will look for ways to lessen the impact of the rule. Their first line of defense will be to modify their pre-admission process to include diagnostic testing as a method for determining if potential patients have any of the conditions identified by the rule prior to admission.

The fallout from the rule will center on who will ultimately bear the cost as a result of the rules' implementation and how such cost will impact the delivery of service to patients.

Another possible impact of the rule is the possible reduction in services by hospitals to critically ill patients who are at a high risk of acquiring some of the conditions included in the rule as never-events during a hospital stay. It could also result in earlier discharge of critical patients from hospitals.

In other words, the Medicare rule, while addressing the critical issue of patient safety, could open the door to higher patient cost and decreased care in the efforts by the hospital to avoid the cost associated with the rules' application.

At first glance, Medicare's new rule may appear to be reasonable as a general proposition; however, it will be at the center of payment disputes between the hospital, Medicare and private insurers. The language of the rule will be tested to get a more finite determination of the scope of its application.

The question of whether the medical error was preventable will be a source of specific dispute. Many argue that the term "preventable" in the context of the rule is vague, ambiguous and, for some of the identified conditions, not measurable.

Hospital representatives argue, for example, that serious and costly infections like those identified by the rule can occur even when doctors and nurses take all the recommended precautions. They posit that paying for conditions without exception does not take into account that some of the conditions on Medicare's list may not be preventable.

The question hospitals and other medical personnel are asking is "how do you determine preventable error from unfortunate circumstances or events that could not be prevented by any number of safeguards"? (i.e. conditions such as fluctuations in blood sugar during surgery).

Another source of dispute will be over the interpretation of the phrase "clinically significant harm." The rule currently makes no distinction between degrees of harm, whether it is trivial or significant, leaving the decision to withhold payment in a grey area which will allow use of subjective criteria rather than objective criteria in the determination of the issue.

CMS has no clear methodology in place to make a clear determination of this issue and it, like other provisions of the rule, will be a major source of payment disputes.

Medicare's new rule, while seeking to address patient safety, a major concern in the healthcare arena, will give rise to disputes between hospitals, insurers and patients over its application. Given this reality, an apparent query for healthcare providers and insurers alike will be, "What is the best forum to resolve these disputes"?

In light of the economic climate and rising cost for the delivery of healthcare services, an obvious concern will be the price tags associated with resolving these disputes. Many lawyers and their clients are looking for alternatives to the high cost associated with litigation.

Alternative Dispute Resolution (ADR) is a growing option for dispute resolution and a viable forum for issues that arise in the healthcare arena. ADR, especially mediation, is a good fit for the disputes that will arise as a result of the application of the Medicare rule.

Mediation is an appropriate forum in this instance, because it provides a neutral environment which is especially appealing to the health arena.

Neutrality is a key component for parties to a dispute who have an interest in maintaining confidentiality and preserving existing relationships. It diminishes the adversarial bite often found in court litigation.

Mediation is less expensive and more efficient than litigation and it allows parties to reach agreement around monetary and non-monetary values. The average mediation is completed in one session, allowing the parties to achieve a speedy resolution of their issues. This will be an important consideration in the healthcare arena, which often deals with time-sensitive issues regarding patient care.

Mediation is party-driven and empowers the participants to reach resolution of an issue on their own terms. The role of the mediator is to facilitate open communication between the parties, making sure everyone has an opportunity to discuss the issues. Mediation gives the parties full control of the decision-making process, an option that is not available in litigation.

The parties to mediation have the ability to choose a neutral with experience in the healthcare arena. This significantly diminishes the need to educate the neutral on healthcare matters.

Finally, the process is confidential and unless the parties agree otherwise cannot be publicized or used in any future contested process.

Mediation, as opposed to litigation, puts the parties in control of the process; it is time sensitive; it encourages collaboration and at the same time offers the parties an efficient process to resolve critical healthcare disputes. Mediation allows relationships to survive the rigors of dispute resolution, thus preserving a key component in the maintenance and growth of the healthcare industry.

— By Bernetta D. Bush, JAMS Chicago Resolution Center

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