THE NEW CMS
NEVER EVENT RULES

KARI ZANGERLE
Campbell, Yost, Clare & Norell
"Whatever happens, the Government better not get involved with my Medicare."
New CMS Reimbursement Rules

August 2007: Centers for Medicare and Medicaid Services (CMS) issued a significant rule changing the Hospital Inpatient Prospective Payment System (IPPS) for fiscal year 2008
The new rule is also known as the “Never Events” rule

“Never Events” defined: Hospital acquired conditions that CMS has deemed “preventable”
How does the Never Events Rule affect Medicare payments?

- No payment under secondary diagnosis code unless documented as present on admission (“POA”)
- What does POA mean? It must be documented within the first 24 hours of admission—otherwise, the hospital will not get paid for treatment of the condition
TIMELINE

How did this new rule come about?
Medicare

- Medicare when originally enacted was a primary payer

- In 1980, under the MSP statute, Medicare became a secondary payer after other potentially responsible parties.
JCAHO

- **1996** Sentinel Event Program created

- **2002** First set of National Practice Safety Goals developed (they are updated annually)
Institute of Medicine

• In 1999 they published a report laying out an approach to preventable medical errors.
• The Report set a goal of 50% reduction of errors over the next 5 years
March 2002

- The National Quality Forum (NQF) published Serious Reportable Events in Healthcare which consisted of a list of 27 adverse events in patient care which NQF said should never occur—hence the name “never events”.
The NQF endorsed a series of 30 “safe practices” that should be “universally utilized in applicable healthcare settings to reduce the risk of harm resulting from processes, systems or environments of care.”
December 8, 2003

President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003.
December 2005: The Deficit Reduction Act was passed

• Required Secretary of Health and Human Services to select 2 hospital-acquired conditions that would be subject to “quality adjustments” in DRG payments in fiscal year 2008.

• The conditions must be high cost, high volume and reasonably preventable.

• The conditions identified were of a type that would normally result in the hospital receiving the higher paying DRG for the secondary diagnosis.
2006

- The NQF revised the “safe practices” list.
- NQF revised the list of “adverse events.”
- CMS made a public statement on “Never Events” stating it will investigate ways to reduce them.
August 22, 2007--CMS releases 1000-plus pages of final fiscal year IPPS 2008 rules
The New CMS Rules

One significant change--Medicare will no longer pay the costs for “certain preventable conditions” or “never events” acquired in the hospital.
October 1, 2007—Effective date for New CMS Rules

• For Fiscal year 2008 (Oct. 1, 2007-Sept. 30, 2008), Medicare will begin to accept a Present on Admission (POA) Indicator for every diagnosis on Inpatient Acute Care Hospital Claims (October 1, 2007).

• Beginning January 1, 2008, hospital providers must provide the POA indicator on all claims.
What do the documentation rules mean?

• If a patient develops a condition that CMS has deemed a “preventable condition” while in the inpatient hospital setting, it must be reported to CMS.

• However, there is no loss of reimbursement for fiscal year 2008.
October 1, 2008-- Nonpayment provisions apply

• Discharges on or after October 1, 2008, will no longer receive additional payment.
What do the nonpayment rules mean for hospitals?

• The condition will not qualify as a secondary diagnosis that can increase the level of severity and thus the level of payment unless the condition is documented as POA.
Preventable conditions

- Object left in during surgery
- Air embolism
- Blood incompatibility
- Catheter associated urinary tract infections
- Decubitus ulcers (pressure ulcers)
- Vascular catheter associated infections
- Surgical site infections
- Hospital acquired injuries
Other conditions CMS may add in the future

- Staphylococcus aureus septicemia
- Ventilator associated pneumonia
- Deep vein thrombosis
- Methicillin Resistant Staphylococcus aureus (MRSA)
- Clostridium Difficile Associated Disease
Risk Areas for Hospitals Resulting in Loss of Reimbursements
Risk to Hospital--Failure to find and document all conditions POA

Problem—some conditions may not always be evident or identifiable on admission.
Conditions which may not be readily identifiable

Example: Pressure Ulcers--what looks like just a bruise or small red mark may in fact be a decubitus ulcer.
**Example:** patient may have a developing infection, but their body has not mounted a response yet which allows the physician to diagnose it (i.e. fever, elevated white blood cell count, redness or drainage at wound site).
Risk to Hospital--Excessive number of “re-dos”

• If there is a coding error, who makes decision to change it?

• What justification is given for coding error?

• What if condition appears 24 hours after admission, under what circumstances can coding be changed to POA?
Risk to Hospital--Failure to have Systems in Place for Evaluation

• **Problem**: If patients frequently remain in ED for up to 24 hours or more before admission, what healthcare provider(s) are responsible for doing “head to toe” of patient for POA documentation?

• **Problem**: What if hospital bylaws do not require that the patient be seen in sufficient time to facilitate POA documentation?:?
Evaluation—who’s responsible?

• Who is responsible for making decisions as to what is POA? (role of nursing staff, physicians, other providers)

• What oversight is provided to monitor POA decisions?

• Standardized documentation?

• Standardized procedures?

• Standardized training?
Avoid Over-inclusion

- CMS will look for over-coding; they will compare admitting diagnoses with discharge diagnoses.
- Must balance risk of over-inclusion with risk associated for failing to document POA.
Potential Fall-out from New Rule
AND FINALLY DOCTOR QUESTION 456(c)... CAN YOU THINK OF ANY AREAS WHERE SPENDING COULD BE CUT WITHOUT DAMAGING PATIENT CARE?
Decubitus Ulcer Example

• Patient admitted for one diagnosis; while hospitalized secondary diagnosis is discovered but not within POA 24 hour window (i.e. decubitus ulcer); patient remains hospitalized for 2 weeks for treatment of secondary diagnosis; hospital won’t get paid higher DRG for treatment associated with secondary diagnosis.
Did you know?

• Decubitus Ulcers are the 4th most requested rider for extra days in the hospital.

• Acute care hospitals treat approx. 2.5 million pressure ulcers each year.

• 15% of hospitalized patients may have pressure ulcers at any one time
Take decubitus ulcer example a step further.

What if patient has to be transferred to a SNF for further treatment of decubitus ulcer? Who pays?
Increased Malpractice Lawsuits
Will the “never events” list become a list of de facto “breaches in the standard of care” which plaintiff’s attorneys will use to prove malpractice thereby increasing payouts for settlements and verdicts?
Audits

- State audits
- Medicare audits
- Licensure and regulatory issues
Negative media attention
What should hospitals do now?
Prepare, Prepare & Prepare
• Create a plan

• Update P & P’s and Medical Staff Bylaws
Create standardized forms for documenting POA conditions and to facilitate head to toe assessment.

WE NEED TO DO SOMETHING ABOUT EXCESSIVE ADMIN, I WANT YOU TO FILL OUT ONE OF THESE REPORT FORMS EVERY TIME YOU THINK YOU'RE DOING SOME...
Train and educate all employees and medical staff
Coordinate with medical staff to ensure compliance
Evaluate the need for and purchase additional equipment
Evaluate the need for and hire additional staff

OF COURSE, IN THE LONG RUN WE'D LIKE PATIENTS TO SEE AN ACCOUNTS CLERK, NURSE AND RESOURCE ALLOCATION MANAGER BEFORE THEY GET ANYWHERE NEAR THE DOCTOR.
• Develop financial forecasting and budgeting.

• Use QA and root cause analysis to identify failures in system and implement a fix.
Appoint persons to manage and oversee entire system

"In addition to your juggling, what other background do you have in medical management?"
Appoint committee to develop plans, forms, and be in charge of implementation.
The Future?

• Expansion beyond inpatient setting
• Financial incentives for reporting and compliance
• Value Based Purchasing ("pay for performance")
• Increased use of False Claims Act (if a hospital bills Medicare for substandard care, is this a False Claim?)
VALUE BASED PURCHASING
What is value based purchasing?
VBP

• Makes Medicare more than a passive payer of claims.
• Instead, Medicare is an active purchaser of care and makes a portion of hospital payment contingent on actual performance on specified quality measures.
Hospitals ranked on core quality issues

- Hospitals between 21% and 80% range of all hospitals will receive the regular DRG reimbursement.
- Hospitals above the 20% range of all hospitals will receive a 5% bonus.
- Hospitals in the bottom 20% of all hospitals for performance, will lose 5%.
• CMS is currently ranking and publicizing lists of poor performing nursing homes.

• As of October 2007, there were 128 special focus facilities (SFFs), out of about 16,000 active nursing homes.
The Future?

• In **2009**, all hospitals who receive Medicare payments will be ranked on core quality care issues.

• **April 2008**—New Home Health Pilot Program will be implemented to study costs and possible cost reductions. Will involve competitive bidding.
What is the False Claims Act?

Federal law that provides liability for *knowingly* filing a false claim for payment with the government.
“Knowingly”

• While the False Claims Act provides for liability for “knowingly” submitting a false claim, it does not require that the person submitting the claim have actual knowledge that it is false.

• A person who acts with deliberate ignorance can be found to have “knowingly” submitted a false claim.
We tried dedicating this computer to deciphering our doctor’s handwriting
Reverse false claim

• **Example**: Hospital receives money to which it knows it is not entitled and then submits false statements or records in order to retain the money.
Qui tam action

- Private parties may bring an action on behalf of the United States under the False Claims Act.

- The private party then is entitled to share in a percentage of the proceeds the government is able to recover as a result of the action.
Qui tam action

• Lawsuit by private party is filed under seal with a copy sent to the U.S. Attorney General.

• United States is given the opportunity to intervene in the suit.
Whistleblower Protection

The FCA provides protection for employees who file qui tam actions from harassment and discrimination and the employer can be subject to penalties including reinstatement, back pay etc.
THANK YOU!

...for your attention.