



Welcome to Neverland

MyHealthGuide Source: **Jason C. Davis**, Global Excel Management, 4/20/09,
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Though rare, *Never Events* do happen. In fact, leaving a sponge behind in surgery was such a measurable occurrence that there are now surgical sponges inserted with radio chips to ensure that they are not forgotten (www.clearcount.com).

After the Centers for Medicare and Medicaid Services (CMS) released a statement that they were no longer going to reimburse for procedures considered to be the error of the healthcare service provider, Aetna, Cigna, WellPoint, and various Blue Cross/Blue Shield plans soon followed with variations of their own reimbursement policies regarding *Never Events*. On January 9, 2009, HCC Life issued a release that these events would be excluded from their stop-loss reinsurance policies.

Stop Loss and *Never Events*

Self-Insured Payers are asking many questions as a consequence: should we exclude *Never Events* in stop-loss policies or plan descriptions? Will my client's members be protected from the balance from non-reimbursement?

- **Firstly, what is a *Never Event*?** The National Quality Forum defines never events as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility” (www.qualityforum.org). Currently, there are 28 *Never Events*.
- **Secondly, how were *Never Events* handled before the advent of denying reimbursement?** By and large, plans paid for these expenses and would recover medical expenses from malpractice rewards from suit issued by the patient (if applicable). For interest's sake, I reviewed key words related to the 28 *Never Events* in a legal database and I found numerous cases that fit this profile.

I believe the perspective in the past was that medical errors are akin to accidents or misadventures. As we know, most accidents are covered in self-insured plans; so why should *Never Events* be an exception?



Market Perspective

A study by the Midwest Business Group revealed that 95% of employers say that hospitals should not bill for any costs associated with “*Never Events*.” But not all were as keen:

While employers say never-event charges should be waived, only 68% of a group of health care industry stakeholders—including hospitals, public health officials, and health plan and medical providers—agree with that position, according to the survey. (Joanne Wojcik – Business Insurance)

Despite a disparity in response between employers and providers, providers are in agreement with the goal of the initiative, which is patient safety, but they have concerns with the current method of denying payment – preferring that the provider voluntarily dismiss the charges associated with the so-called *Never Event*.

This is the method advocated for by the Leapfrog Group. The Leapfrog Group has focused on this issue and they recommend the following plan of action for healthcare facilities:

- We will apologize to the patient and/or family affected by the *Never Event*.
- We will report the event to at least one of the following agencies: The Joint Commission, as part of its Sentinel Events policy*; state reporting program for medical errors; or a Patient Safety Organization.
- We agree to perform a root cause analysis, consistent with instructions from the chosen reporting agency.
- We will waive all costs directly related to a serious reportable adverse event (www.leapfroggroup.org).

Should I change my plan language?

Though the definition is fairly new, the concept on not paying for these types of events is arguably not new to self-funded plans. Most plans that I review already have a medical necessity clause. That is, the plan does not pay for procedures that are not helpful for the treatment of a said disease state. As such, one could argue that *Never Events* are already not reimbursable in the scope of most plan descriptions (see CIGNA’s Reimbursement Policy for a succinct summary of this dynamic – www.cigna.com (RO5)).

Nonetheless, I confirmed with some litigators that defend providers; plans will want to consider adding some language so that they can protect their interests in case of a dispute. These changes will require strong communication with the stop-loss carriers to ensure that the Plan is denied reimbursement on a “debateable” *Never Event*.



Operational Changes are necessary to screen for *Never Events*

In his article, *Never Events May Never Happen*, **Fred Hunt** candidly reports that the voluntary dismissal of charges and an apology to the patient have never been detected across the entire SPBA membership. This can either mean that there are no *Never Events* or that voluntary guidelines have failed, as they so often do. Also, payers are often not systematically screening for diagnosis codes that could be linked to *Never Events* for audit and manual review. For over a year, hospitals have been reporting present on admission (POA) indicators, but few payers have adjusted their claims system to screen for these.

Present on admission (POA) indicators helps group the conditions into the right diagnosis related group (DRG), which is the basis for reimbursement under Medicare. For example, if a member presents with a condition and develops a bedsore (stage 3 ulcer) not present on admission, then it would be excluded as a complication, and the grouper would likely group to a lesser reimbursing DRG. However, since most plans are paid on a percentage of savings (through a PPO), further analysis would have to be done for procedures to remove the billed charges associated with the *Never Event*.

Will the member be balance billed?

Twenty (20) state hospital associations have adopted their own response to *Never Events*, and so have 17 payer associations (Source: Modern HealthCare *Never Event* lists).

There are some measurable differences between the payer and provider mentalities on *Never Events* and any sweeping policy regarding *Never Events* will be met with challenges. As such, the patient will likely be billed for the balance and they will be caught in the cross-fire. Bear in mind that these observations represent the organizations that have taken official positions regarding *Never Events*; the majority of state hospital associations are still formulating their official responses.

How can payment be denied without compromising the member?

The procedure for identifying these events begins with programming a claims adjudication platform to “red-flag” any diagnosis codes that are linked to *Never Events*.

According to uniform billing standards, providers must report whether or not these conditions (diagnoses) were present on admission (POA indicators). Once these cases are identified, the plan should review the complete medical records to make a determination as to whether a never-event occurred. The Plan or review agent must also have (or develop) expertise in carving out the expenses directly attributable to the *Never Event*.



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Once this report is acquired, the applicable payment should be made and the *Never Event* liability should be denied; an adverse determination letter should be sent to the patient with an explanation.

As this is a case-by-case procedure, one must consider that the provider will challenge the Plan's position, and will attempt to discuss the matter so that a resolution can be achieved. At worst, they will file a lawsuit. Alternatively, the provider may simply bill the patient for the balance. Without an action plan in place, a payer could face a problematic situation.

Collectively, the reinsurer, the TPA, the employer and the member need to manage and finalize the dialogue that would ensue from a *Never Event*. As appropriate, the carrier may have to consider filing an extension to the payment deadline until these issues are finalized.