

# Never Say Never

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## **CMS extends 'Never Event' non-payment policy to Physician services**

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Given continuing downward pressure on reimbursement and increasing emphasis on quality, it was bound to happen sooner or later: the Centers for Medicare & Medicaid Services (CMS) has extended Medicare's policy of non-payment for "Never Events" beyond hospital inpatient services to both outpatient services and service of non-facility providers, *including physicians*.

Recent history suggests that this virtually inevitable initial extension is a harbinger of things to come.

In 2002, in order to facilitate a national "event reporting system" that could improve patient care, the National Quality Forum (NQF) developed a list of 27 events that it declared to be "serious, *largely preventable* and of concern to both the public and health care providers." By May 2006, however, CMS effectively did away with the NQF's "largely" qualifier and declared that "never events" are "errors in medical care that *are* clearly identifiable, preventable, and serious in their consequences for patients."

One year later, in October 2007, hospitals paid under the inpatient prospective payment (DRG) system were first required to report whether certain diagnoses were present on admission. Fast forward another 12 months and that *reporting* program had evolved and expanded into a reporting and *non-payment* policy. Beginning Oct. 1, 2008, Medicare ceased paying hospitals a higher reimbursement rate (enhanced DRG) for a hospitalization if the sole reason for the higher rate was any of 12 complications or comorbidities (a hospital-acquired conditions or "HACs") that had not been reported as being present upon admission. CMS had initially proposed six additional HACs, but omitted them from the final rule. Whether any of those six will resurface in 2010, with or without additional HACs, remains to be seen.

As with new payment methodologies, the never event phenomenon rapidly spread beyond the Medicare program. In June 2008, the Michigan Health and Hospital Association announced that its members would not bill for 11 never events. By the fourth quarter of 2008, virtually every major commercial payor, including Aetna and CIGNA, had adopted a never events non-payment policy and

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had modified its provider contracts accordingly.

Despite the increasing momentum of the never events freight train, few physicians paid much attention to it. After all, it jeopardized only hospitals' reimbursement. That all changed on Jan. 1, 2009, when CMS issued three new National Coverage Determinations (NCDs).

Medicare covers only items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury and are within the scope of a Medicare benefit category. NCDs are essentially Medicare coverage decisions or rules that apply nationwide. The three new NCDs declare that any medical care necessitated by (i) performance of the wrong surgical or invasive procedure; (ii) performance of a surgical or invasive procedure on wrong body part; or (iii) performance of a surgical or invasive procedure on the wrong patient is *not* a reasonable and necessary treatment for the Medicare beneficiary's particular medical condition and thus, *not covered by Medicare*. Significantly, the new NCDs broadly define "surgical and other invasive procedures" as "operative procedures in which skin or mucous membranes and connective tissue are incised **or** an instrument is introduced through a natural body orifice."

In contrast to the HAC non-payment rules, which apply to only inpatient hospital services, the new NCDs eliminate Medicare coverage and, therefore, preclude payment for services necessitated by any of the three types of errors, regardless of whether those services were furnished by a hospital on an inpatient or outpatient basis, *or by a physician or other healthcare professional provider or supplier*.

Based upon hospitals' experience with never events, the new NCDs suggest that physicians should expect to see (i) similar non-payment policies imposed by the major commercial payors, and (ii) an increasing number of never events and HACs made subject to non-payment by both Medicare and commercial payors.

For several reasons, these policies may prove even more problematic for physicians than they have for hospitals. One of the major reasons is that, unlike hospital reimbursement based upon DRGs, the fee-for-service reimbursement currently received by most physicians is much less susceptible to allocation and adjustment based upon specific factors that necessitated the services to which the reimbursement applies.

When you see troublesome reimbursement compression mechanisms applied to non-physician providers, never say never. You're most likely already in the bullseye.

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