

# Preventive Action

Quarterly Risk Management Newsletter for Policyholders of APAC

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## Mandatory Reporting Medicare Secondary Payer Act

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**Effective January 1, 2010**, the Medicare Secondary Payer Act [42 U.S.C. 1395y(b)(7) & (8)] requires that all liability carriers report payments made to any Medicare plaintiff/claimant to the Center for Medicare and Medicaid Services (“CMS”). This reporting requirement may also apply to payments made directly by a physician and by “self-insured” physicians.

**Anesthesiologists Professional Assurance Company will report payments made on behalf of its policyholders to CMS. For payments made by a physician directly to a claimant, the physician may be responsible for reporting to CMS. See reporting information below.**

Reports must be submitted to the CMS in electronic format only, on CMS website at [www.com.hhs.gov/MandatoryInsRep](http://www.com.hhs.gov/MandatoryInsRep). However, the **electronic** reporting may be waived when there is no method available for the submission of claims (a) in an electronic format; (b) for a provider

of services with fewer than 25 full-time equivalent employees; or (c) for a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

Reporting thresholds by payment year and amount are:

- 2010 - over \$5000.00
- 2011 - over \$2000.00

CMS will assign each registered liability carrier a specific date for reporting every quarter. If a physician makes a payment directly to a plaintiff/claimant which meets the reportable threshold, CMS should be contacted as soon as possible regarding how and what to report. Generally, the report date is determined by the date of settlement, date of verdict, or date of appeal result, not the date that payment is made.

### Factors to consider in determining whether you must report a payment:

1. Is the plaintiff/claimant a Medicare recipient?

Look at the entitlement at the “time of incident”:

- Persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement Benefits;
- Disabled persons (totally disabled) receiving SSDI;

- Persons of any age who have received Social Security, widows or Railroad Disability Benefits for 25 months (this may apply to disabled minors/adults);
- Persons with end-stage renal disease who require dialysis treatment or kidney transplant; and
- Working persons over age 65 that are not eligible for either Social Security or Railroad Retirement Benefits who purchase Medicare coverage by monthly payment or as active employees for an employer of 20 or more employees.

2. Is the payment over the dollar threshold for the year it was made?

### If you must report, how and what do you report?

Generally, unless a waiver is received for **electronic** reporting, every report must contain the following information for each claimant:

- Name of claimant (with middle initial);
- Social Security number (HICN when available);
- Complete address;

*Continued on page 2*

### TABLE OF CONTENTS

Page 2	Safety Concerns of Patient-controlled Analgesia
Page 3	Inappropriate Documentation Constitutes Fraudulent Record
Page 4	Legal FAQs



Anesthesiologists Professional Assurance Company



Anesthesiologists Professional Assurance Company publishes Preventive Action on a quarterly basis as a service to policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. Anesthesiologists Professional Assurance Company recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions or to obtain additional copies contact the Anesthesiologists Professional Assurance Company Risk Management department at 866-294-6014, ext. 3016.

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Continued from page 1

- Telephone number;
- Gender;
- Date of birth;
- Date of death, if applicable;
- Full contact information on any estates, siblings or other representative claimants, if applicable;
- Full contact information for claimant’s attorney including tax ID numbers, if applicable;
- Dates and the nature of any injuries, including whether the injury involved an allegedly defective product, if applicable;
- Information detailing any resolution or settlement of a claim, with a focus on explaining whether the claim was contested or not, and whether the primary payer has assumed ongoing responsibility for medical costs associated with the claim.

There are very **steep fines** (\$1000 per day, per claimant) for failure to report pursuant to these requirements.

The reporting requirement does **not apply to Medicaid** recipients.

Contact CMS at [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep) or by phone at 800-999-1118. Additional information may be also be obtained by contacting the APAC Risk Management Department at 800-741-3742 ext. 3016 or e-mail at: [rm@fpic.com](mailto:rm@fpic.com). ➔

## Safety Concerns of Patient-controlled Analgesia

The Anesthesia Patient Safety Foundation (APSF) recently published recommendations for improved detection of postoperative opioid-induced respiratory depression, chiefly continuous monitoring of oxygenation (pulse oximetry) and ventilation in patients receiving PCA or neuraxial opioids in the postoperative period. Even if ventilation assessments are performed intermittently during routine nursing observations, “the use of respiratory monitoring technology (capnometry) would improve the detection of progressive or unrecognized hypoventilation”.

APSF summary recommendations include:

- Individualize the dose and infusion rate of opioid while considering the unique aspects of each patient’s history and physical status
- Make continuous monitoring of oxygenation (pulse oximetry) the routine rather than the exception
- Assess the need for supplemental oxygen, especially if pulse oximetry or intermittent nurse assessment are the only methods of identifying progressive hypoventilation
- Consider monitoring ventilation (even if intermittent) with technology capable of detecting progressive hypoventilation.

APSF Volume 44, No. 2, 25-32. 2009 ➔

# CASE STUDY: Inappropriate Documentation Constitutes Fraudulent Record

*Editor's Note: This case analysis reflects an actual First Professionals' case.*

## CASE ANALYSIS

This case involved a patient undergoing surgery who experienced cardiac arrest without successful recovery. Timing factors in the anesthesia record were inconsistent with the Code Blue documentation. According to the times recorded in the nurse's record on the code sheet, anesthesia monitoring would have stopped 10 minutes before resuscitation began. The anesthesiologist, being certain that there was no time lapse in the monitoring of the patient, assumed his time documentation in the anesthesia record was wrong and subsequently adjusted the record to coordinate the times with the code sheet in an effort for clarification. At trial, it was discovered that the anesthesiologist had altered the record. Consequently, the medical record was deemed fraudulent, and the case rendered indefensible. During the criminal investigation that was initiated against the anesthesiologist for the record alteration, it was determined that there was indeed a 10 minute time difference between the anesthesiologist's wristwatch and that of the clock on the operating room wall.

## Risk Management Discussion

Documentation is a key tool for defending medical malpractice cases. Improper documentation or the lack of supporting documentation may actually contribute to a finding of negligence. Consider the following recommendations:

- Document with specificity
- Never alter the medical record
- Corrections to the records should be initialed and dated contemporaneous with the correction made
- Never use "White Out" or otherwise attempt to cover original record entries – line through an erroneous entry and initial and date the change made
- Provide an explanation in the record for inconsistencies
- Document your medical rationale
- Ensure the same integrity of documentation made electronically
- Entries should be legible, and contain sufficient detail to clearly demonstrate why the course of treatment was undertaken or not undertaken
- Documentation should support the diagnosis, justify the treatment, and be accurately dated and timed
- Ascertain if timing inconsistencies exist and determine the etiology
- All OR staff should synchronize timing devices prior to every procedure
- Seek legal or risk management advice when uncertainty arises

*This information does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. APAC recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.*



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## Legal FAQs For information specific to your state of practice, contact APAC's Risk Management department



### **What is a 'tort'?**

A civil wrong or injury for which the court will provide a remedy in the form of an action for damages.

### **What is meant by 'discovery'?**

Pre-trial devices that are used by one party to obtain information about the case. Forms of discovery include depositions, written interrogatories, production of documents or things including medical records and personal records. Discovery could also include physical and mental examinations, requests for admission and information necessary to support a claim for damages.

### **What action should be taken when a patient is noncompliant or refuses to undergo diagnostic studies, care, or treatment?**

Document your recommendations and the patient's noncompliance. Advise the patient of the potential consequences of their noncompliance or refusal and document your discussion. Confirm the patient's noncompliance, your subsequent discussion and the potential consequences in a letter to the patient sent certified mail, return receipt requested and send a copy of the letter by regular mail as well. Consider withdrawing from the patient's care, but first review the language of any managed care contracts that may apply to the situation and seek guidance from APAC's Risk Management Department or personal counsel. If you practice in a group setting, it may be necessary to withdraw on behalf of others in the group and the practice itself.

### **What is an 'adverse drug reaction' (ADR)?**

An undesirable response associated with use of a drug that either compromises

therapeutic efficacy, enhances toxicity, or both.

### **What does the acronym 'FMECA' stand for?**

Failure Mode, Effect, and Criticality Analysis. A systematic way of examining a design prospectively for possible ways in which failure can occur. It assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.

### **What is meant by 'risk containment'?**

Immediate actions taken to safeguard patients from a repetition of an unwanted occurrence. Actions may involve removing and sequestering drug stocks from pharmacy shelves and checking or replacing oxygen supplies or specific medical devices. ●