



Minimizing medical errors is on healthcare's docket

HealthPartners' move reiterates ideal for industry-wide accountability

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NATIONAL REPORTS—HealthPartners' recent decision to withhold payment for procedures that go wrong reflects the growing concern that insurers and employers have about the quality issues and costs that result from avoidable medical errors—the 27 "never events" as identified by the National Quality Forum.

"Health plans traditionally have taken a more subtle approach when seeking to deny or limit payments to providers who botch the job, such as treating the care as not meeting medical necessity or appropriateness criteria," according to Cynthia Stamer, partner with Epstein Becker Green Wickliff & Hall's National Healthlaw practice. "The clear statement by HealthPartners ... reinforces the efforts by employers participating in the Leapfrog Initiative and other groups across the country collaborating to minimize medical errors.

"While no provider wants to commit medical errors, tying payment to performance helps get the entire healthcare delivery team on board with efforts to prevent mistakes by sending an important message both to the licensed healthcare providers rendering the care and the operations management in the hospitals and other venues," Stamer says.

According to Mike Cowie, partner, Howrey Simon Arnold & White LLP, HealthPartners' efforts in this area are consistent with the approach of the Minnesota state legislature and "thus should not be subject to litigation or other challenges.

"HealthPartners would hold payments only for certain practices by hospitals that are clearly erroneous and harmful to the patient," Cowie says. "These are specific acts that the Minnesota legislature has identified as improper and subject to mandatory state reporting requirements."

Included among the 27 "never events" under Minnesota's New Adverse Health Care Events Reporting Law are surgery performed on a wrong body part; retention of a foreign object in a patient after surgery or other procedure; an infant discharged to the wrong person; and patient death or serious disability associated with the use or function of contaminated drugs, devices or biologics provided by the facility.

Some health insurers and other payers, Stamer says, historically might have been reluctant to make a clear statement that its decision to deny coverage is based on factors such as:

- Uncertainty about the legal position and exposure resulting to health insurers for making "medical judgment"-based coverage decisions triggered by a series of court decisions over the past decade; or
- Concern that declaring denial of care because the provider made a mistake might unnecessarily involve the health plan in litigation that should be malpractice litigation between the patient and the provider.

Following the Davila decision, health plans generally feel more comfortable about their ability to make and sustain coverage decisions based on medical judgment or other quality-related criteria written into their structure, according to Stamer.

"Health plans also increasingly are working to communicate more clearly information about the basis of their medical-based judgments to providers and participants," she says.