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Vol. 9 No. 4 October—December 2012
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Potential Long Lasting Repercussions of Medicaid Audits

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In the past, a Medicaid audit was annoying, intrusive, costly, and frustrating. While the procedure for Medicaid audits have not eased any of those issues, newly implemented statutes and changes to the Florida Medical Practice Act have added a new and significant complexity to defending Medicaid and Medicare audits.

Not only has Medicaid increased its fines regarding decisions of overpayments, the Department of Health now has a directive that should a provider be terminated for cause from the Medicaid program, that provider's professional license will not be renewed. In the past, fines for violation of the Medicaid payment rules were minimal ($1,000- $5,000). Now, however, the fines have increased to $1,000 per violation cited and up to a maximum of $20,000, or the total repayment demand, whichever is less.

In the past, many Medicaid providers would ignore or regard repayment demands lightly. At times, providers would merely acquiesce to the request without putting up any defense to the audit, as the cost of defending the audit generally outweighed the amount demanded on repayment. In the past several years, however, the repayment demands have dramatically increased, due to the use of extrapolation; thus making it necessary for providers to respond to the audits in a more proactive way. Even with those demands, many providers have chosen to ignore audit requests or violate final orders with regard to settlement agreements, as Medicaid did not strongly seek reimbursement in the past. As a result, many providers would merely be terminated from the program. After enduring lengthy audits, providers often would welcome the opportunity to stop participating in Medicaid.

Two years ago, however, the Florida Legislature passed what has been referred to as Senate Bill 1986 which is presently codified under §456.063, Fla. Stat. That statute states, in pertinent part:

> (2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant: ….
>
> (c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
>
> (d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application; or
> (e) Is currently listed on the United States Department of Health and Human Services

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Office of Inspector General's List of Excluded Individuals and Entities. [Amendment in 2012]

Subsection 2(c) clearly indicates that the Department of Health can deny and "refuse to issue a license" to any healthcare provider who has been terminated for cause from the Florida Medicaid program. Of note, the additional sentence to include a "good standing" exception has been a focus of some interest. On its face, it would appear that this sentence may be an important exception. However, §409.913, Fla. Stat. requires a sanction of suspension for one year following any indictment for Medicaid or Medicare fraud, regardless of outcome. Thus, even if a provider is not convicted, they still run the risk of termination from the program pursuant to §409.913, Fla. Stat. Regardless of whether the provider has had a stellar record, that one-year suspension will remove the "good standing" exception as a means of protection for that provider. Initially, because all Medicaid audits are conducted pursuant to §409.913, Fla. Stat. through Medicaid Program Integrity, it will likely be argued that a failure to comply with the audit request or failure to comply with the terms of the final order would also be considered outside of the "good standing" exception and thus, the provider would lose that protection through such inaction or non-compliance. In fact, it could even be argued that any audit even one which is complied with by the provider might be considered to remove the "good standing" exception. It is a rare circumstance that Medicaid would terminate a provider for cause pursuant to §409.913 Fla. Stat without any prior audit or other history with Medicaid. Therefore, while it may appear that the exception sentence might be helpful, it is anticipated that Medicaid will assert that any action pursuant to §409.913, Fla. Stat. would remove that exception.

Fla. Stat. §456.063(2)(d), raises its own concerns. What may appear to be a disregarded subsection has significant impact, especially for Florida providers who are licensed in other states. For example, like most other states, the state of New York reviews Board of Medicine orders and other final agency actions in Florida. Interestingly, in New York, they automatically refer all investigations to their state Medicaid review board. It has come to our attention that in many circumstances, even those physicians with expired New York medical licenses will have their privileges to participate in New York Medicaid revoked based upon actions taken in Florida. We have seen this occur even in circumstances where the Florida actions did not involve Medicaid. Thus, should a provider possess even an expired New York state medical license and his or her Florida medical license is acted upon via a final order, whether through a settlement agreement or otherwise; it is important that the provider engage a New York attorney to make sure that there is no action taken against the provider's expired New York license by New York Medicaid. This is an unfortunate pitfall that has been created by this new statute. While we have yet to see a Florida practitioner lose their Florida medical license based upon this scenario, no one wants to be the "example."

Another very important change in 2012 was the addition of §456.063(2)(e), Fla. Stat. While

this may not apply to many providers, for one reason or another, should a provider be placed on the Office of Inspector General (OIG) exclusion list, subsection (e) would be triggered. As such, we recommend that providers periodically check the OIG exclusion list, both to assure that the provider's name is not inadvertently placed on the list, but also to ensure that any of

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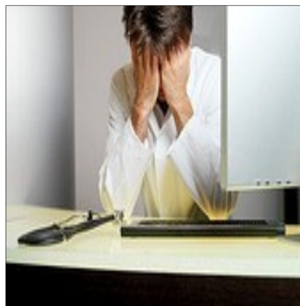
the provider's employees are not included on that list. While an employee's exclusion would not lead to any direct action against the provider employer's license, it will likely lead to repayments and fines to the OIG for submitting payments on behalf of the excluded participant. To view this list, visit http://exclusions.oig.hhs.gov/.

These recent changes to Florida law have added a new wrinkle to the defense of Medicaid audits. In the past, providers often ignored Medicaid audits due to the fact that they no longer desired to participate in Medicaid following the audit process. However, such inaction will now lead to significant, if not permanent effects upon their medical licenses. The take-home message is to be cautious, as Medicaid audits may affect much more than your pocketbook.



Second Victims: To forgive, divine.

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Alexander Pope, an 18th-century English poet, wrote in part, "To err is human; to forgive, divine." Forgiveness can come from very many different sources, but the ability to forgive oneself is often the hardest to come by. Mistakes are a human inevitability. As a result of studies such as "To Err Is Human", increased media attention to medical errors, and organizations like the National Patient Safety Foundation and Leapfrog Group, patients have become savvy consumers of their own healthcare which should stand to benefit everyone involved in promoting patient safety and error prevention. Facilities across the nation have answered the call, promoting a culture of safety, and encouraging reporting of patient safety events so that all healthcare providers can learn from errors and adapt when necessary.

One recent article colorfully entitled "How to Stop Hospitals From Killing Us" provided a number of thoughtful ideas on increasing the transparency of healthcare[1]. One of the central themes of this article was that, "To do no harm going forward, we must be able to learn from the harm we may have already done."[2] No one is more integral to that lesson than the healthcare providers involved in that harm. While transparency is promoted to help others understand and prevent similar errors, many are not sensitive to the fact that the involved healthcare providers often feel guilt and shame, and even a sense of abandonment by their peers. Errors can sometimes have devastating consequences for all those involved and although the patient and their family may be the most obvious victims of the error, they are not the only victims.

An article by Dr. Albert W. Wu, Director of the Center for Health Services and Outcomes Research at Johns Hopkins, and a prominent voice in medical errors and the impact on providers, referenced his own experience. A colleague who committed a medical error was summarily judged and found guilty of incompetence by his peers.[3] Unfortunately, he also found that there was little sympathy for the resident who committed the error. His experiences and his studies of the emotions surrounding a medical error led him to the theory of a second victim. He found that what is most needed is "unconditional sympathy and support" from peers, which can often be lacking. Although support can vary among facilities, most encourage a "no blame" environment where all healthcare providers can feel free to report and discuss events without fear of retaliation or judgment.

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Disclosure of medical errors and apologizing to the patient and their family for their unexpected experience is not only an ethical and legal imperative, but can contribute to the feeling that "ownership" for any error belongs to the entire facility and that the involved healthcare provider is not alone. Sharing the experience of being involved in an error with colleagues and peers is also beneficial because they realize that they are not the only ones that have made a mistake.

Thoughtful and timely disclosure can help lessen the emotional trauma to all victims of an error if conveyed appropriately. Disclosure and proper handling of grief and rage is a learned skill, therefore, prior training on disclosure is recommended for every healthcare provider. Once an error occurs and disclosure is made, healthcare providers often face the daunting task of having their error repeatedly discussed in patient safety committees, morbidity and mortality conferences, with risk managers and often with their supervisors. Where a healthcare provider has been unable or unwilling to face the error, these interactions can force them to break down the causes of the error. As Dr. Wu noted, even when these errors are discussed in a number of forums, "it is to examine the medical facts rather than the feelings of the patient or physician."

Failing to address the feelings of the healthcare provider can lead to destructive and damaging behavior on the part of the second victim. Although there is a spectrum of emotion exhibited by healthcare providers, there are often two very concerning reactions to the error: those that care too much and those that appear to care too little. Each of these is a defense mechanism that has its place in assisting the healthcare provider in assimilating the error, but can also sometimes evolve into a dysfunctional reaction to the events surrounding them. Some healthcare providers may become defensive, blame others for their error and generally, fail to see the part they may have played in the error. They may lash out at their own colleagues, other departments or divisions involved in the patient's care, or may even seek to find fault with the patient.

Other healthcare providers may feel the weight of the error with such force that they cannot stop re-analyzing and reliving it. These healthcare providers are often those most capable of expressing their feelings and of self-reflection. These same characteristics that make them such compassionate and empathetic caregivers, can also make them more likely to hold on to the error, as well as the guilt and shame associated with it. As a consequence, they often blame only themselves, viewing the error as a personal failure, instead of viewing their role in the proper perspective. In fact, even when granted the forgiveness of the patient or their family, they may be unwilling to forgive themselves.

The effects of an error can follow the second victim into their personal life and impair their own physical well-being. Sadness, fear, shame, insecurity and depression can be commonplace. The experience can also be protracted by organizational and regulatory investigations including investigations by their respective licensing boards. Further, if litigation is pursued, the error can remain in the forefront for years to come.

Such appears to have been the widely reported case of Kimberly Hiatt, a highly experienced pediatric nurse from Washington State, who was involved in a medication error that may have contributed to the death of an already fragile 8 month old patient in 2010. Ms. Hiatt appears to have made a calculation error that led to an overdose of calcium chloride. It has been reported that following this incident, she was terminated after 27 years of nursing for reasons unrelated to this inci-

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dent. She was fined and placed on probation by her state licensing board. Seven months after the fatal error, she took her own life. It is unclear how much support she had and what other issues may have contributed to her tragic decision, but it is imperative that incidents like this which compound the tragedy of the error, never occur. This begins with recognition of the impact on second victims and the development of programs that provide an outlet for healthcare providers to share their feelings and provide emotional support to each other.

Charles Denham, chairman of Texas Medical Institute of Technology, proposes five human rights for second victims, which can be remembered by the acronym **TRUST**[4] :

Treatment that is just: Assume innocence and good intentions, and treat all parties fairly.

Respect: No blame or shame for human fallibility.

Understanding: Compassion for the grieving and healing that the second victim will experience.

Supportive care: Psychological and support services.

Transparency: Allow second victims to participate in learning opportunities and the prevention of future medical errors.

Denham goes even further and posits the existence of a "third victim" of medical errors. The medical error itself can also wound the leaders of the healthcare facility as these leaders are placed in the difficult position of caring for all of the healthcare providers and the organization itself, even those with conflicting points of view. If handled incorrectly, the very culture of the healthcare facility can be harmed and the consequences of same could reverberate for months and years to come.

No healthcare provider intends to harm their patients and certainly, the goal is always to provide good care to patients. Under the best of circumstances, healthcare providers deal with illness and loss on a daily basis. They are by their nature, desirous of helping those who are ailing and often form an emotional connection to those patients. When there is loss, it is their loss as well. When the loss is as a result of their own error, the loss can be unbearable. Although there is a clearly defined victim of the medical error in the form of the patient, the harm can go well beyond that patient to the medical staff, the facility and the entire healthcare organization. Not all facilities are equipped to deal with the needs of its staff following a medical error. Fortunately for some healthcare providers, many facilities are mindful of the emotional and psychological toll that a medical error can take on all those involved in the patient's care. These same facilities are instituting mechanisms to assist healthcare providers with the stress and grief caused by medical errors. The importance of second victims and the need for further research and development of a formal program was recently recognized this year through a grant awarded by The W. Martin Smith Interdisciplinary Patient Quality and Safety Awards Program which you can view at www.flbog.sip.ufl.edu.

[1]How to Stop Hospitals From Killing Us by Marty Makary, The Wall Street Journal, September 22, 2012.
[2]Id.
[3]Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. [4]BMJ. 2000; 320 (7237): 726-727.
Denham, Charles. TRUST: the 5 rights of the second victim. J Patient Saf. 2007; 3(2): 107-119.

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