Fickle Finger of Fate

The summer has essentially gone now and at the time of this writing we are still trying to convince Congress that a 10% cut in physician reimbursement is going to force most physicians into making some major changes in their practices. If physicians don't have some procedural or office sales income, many offices are going to close or cut back severely in order to survive. We all are worried about our practices, but hospitals are coming under the "fickle finger of fate" also.

A recent article in the *Wall Street Journal* outlined the payment limitations to begin October 2008 for what is considered a "hospital acquired injury." Eight areas are to be denied by Medicare. Patient falls and their consequences, pressure ulcers, urinary tract infections, vascular catheter infections, and mediastinitis following cardiac surgery will not be reimbursed. "Never events," never should have happened, will also be disallowed. Air embolisms, blood reactions, and objects left in a patient at the time of surgery fall into this category.

What are we to do, restrain all mildly confused patients? Are we to require family to stay with all patients? (That is a two-edged sword!) Are we to increase the chance of pressure sores and skin tears with patient restraints and removing urinary catheters – especially from female patients? Do we limit central venous catheters for critically ill patients and have multiple peripheral catheters?

All of these events are undesirable and many procedures have been developed by clinicians to prevent these complications. However, with the age of the population, the physical condition, and the poor compliance of some patients, the outlook is for increased denials or non-reimbursable events.

Every physician attempts to prevent complications, but the patient must also assume some of the responsibility for increased risk. Also, in my opinion, consideration of the consequences of these rules has not been explored very well by Medicare. The goal to limit payment to providers often produces more risk and limits access to care. As most remember, when monitoring for cardiovascular surgical outcomes became an issue, many elective procedures were declined due to high risk patient complications. What will happen when an overweight diabetic is in need of surgery? A great deal of thought by the physician and hospital will be expended before elective procedure will be completed. This pushes the risk to the emergency arena which is always accompanied by increases in the risk of complications.

Also, this situation will affect the regular insurance "at risk" patients. As we know, insurance carriers complete risk assessment on non-Medicare patients and rate them based on probability of occurrence. Increased risk equates to increased premiums. How long will it be before insurance carriers refuse to pay hospitals for complications? Do you think they will drop premiums? How long will it be before the carriers and Medicare refuse to pay physicians for caring for complications? As a pulmonary critical care

physician, I care for many critical patients with significant risk of complications. Will these effect physicians that care for high risk patients?

Medicare also has a few more little inconveniences to "help" the medical profession. New physicians have been rudely confronted with the need of a new NPI number. The interesting fact is that a new physician can't apply until 30 days before practice is begun. Interestingly, Medicare has up to 120 days to process the application. This disparity could delay reimbursement for weeks. Ramifications not only for direct payments but also co-payments will be experienced by new physicians. Payments will be delayed, in all likelihood, to young physicians deep in debt from their training. Practices that employ young physicians will have to experience more financial strain as new physicians enter practice. It seems that if it can be made difficult, Medicare will find a way to make it so.

Another recent news release suggested that physician-owned hospitals are to come under scrutiny. It seems that physicians will be limited to less than 2% of the hospital ownership in order for the physician to practice at the facility.

What will it take to change the tides of progressive deterioration in the practice of medicine? We obviously have to educate Congress. Very few individuals on Capital Hill have a real understanding of the problems medicine has to deal with. I really think we must reevaluate our options and start to look at more effective ways to address the issue. I think we need to begin to encourage our patients to become more involved. A better method of convincing patients to become vocal and put pressure on Congress has to be developed. Many practices are already failing and physicians are moving to hospitalist employment or evaluating other sources of income streams in order to survive physically, mentally and financially.

Is there time to salvage our profession? You tell me!!!

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