



We're ready to  
**hit the ground running.**

**perot**systems®  
*Break Through*  
www.perotsystems.com/insights

## Modern Healthcare

This copy is for your personal, noncommercial use only. You can order presentation-ready copies for distribution to your colleagues, clients or customers [here](#) or use the "Reprints" link that appears next to any article. Visit [modernhealthcare.com/reprints](http://modernhealthcare.com/reprints) for additional information. [Back to article.](#)

---

Article published March 30, 2009

# Stop the bleeding?

Orthopedic surgeons split on merit of CMS VTE goals

By Andis Robeznieks

Posted: March 30, 2009 - 5:59 am EDT

In seeking to prevent the leading cause of preventable hospital deaths, some orthopedic surgeons say the CMS is elevating the potential for other negative outcomes to increase in number.

Leading the crusade is Greg Brown, associate chief of surgery for outcomes at Park Nicollet Health Services in St. Louis Park, Minn. Brown is concerned that the leading intervention strategy endorsed by the CMS, American College of Chest Physicians, or ACCP, and Surgical Care Improvement Project—prophylactic prescribing of anti-coagulants to prevent venous thromboembolism, or VTE—will lead to increased risk for bleeding. An increase in bleeding boosts the risk for having to re-operate, which increases the risk of infection or other bad outcomes.

“I’m not trying to minimize the seriousness of VTE events,” Brown said. “The concern is that the guidelines are only looking at one outcome—VTE events—and the bleeding outcomes have the potential to be more serious. Now that the guidelines have essentially been made mandatory, we have no options to do what is best for our patients.”

According to Brown, by adopting the ACCP guidelines, the CMS has taken away orthopedic surgeons’ ability to assess and

stratify patients' risk for VTE events, as compared with their risk for post-operative bleeding, and proceed accordingly.

VTE events include deep-vein thrombosis, or DVT, described as a blood clot that commonly forms in the large veins of the legs, and pulmonary embolism, which occurs when that blood clot breaks free and travels to the lungs. Pulmonary embolism has been linked to 300,000 fatalities a year—more than breast cancer and AIDS combined—and is considered the most common cause of preventable hospital deaths. On Oct. 1, 2008, DVT and pulmonary embolism were added to the CMS' list of hospital-acquired conditions in its inpatient prospective payment system. Under the IPPS, Medicare reimburses at a “quality adjusted” (i.e., “lower”) rate for the treatment of these conditions.

The CMS requirements originated as guidelines from the ACCP. The eighth edition of the guidelines was released in 2008, with recent editions released in 2004 and 2001. These 2004 guidelines were adopted as performance measures by the Surgical Care Improvement Project, and the CMS has been reporting adherence to the guidelines since Jan. 1 2007.

These guidelines call for the prophylactic prescribing of anti-coagulants such as heparin or warfarin, while the American Academy of Orthopaedic Surgeons guidelines state that sometimes aspirin works fine or no drugs are needed at all. Both say mechanical compression devices can also be used when there is a high risk for bleeding.

The CMS had no comment on Brown's criticism at this time. “We are evaluating the evidence diligently,” said CMS spokesman Don McLeod.

By speaking out against the guidelines during a March 4 presentation at the American Medical Group Association conference in Las Vegas and noting that the guidelines had created a “firestorm” in the orthopedic community, Brown helped kick off DVT Awareness Month, but not in the way its organizers probably had hoped. Awareness month events were organized by the Coalition to Prevent Deep-Vein Thrombosis, a group of 60 organizations funded by Sanofi-Aventis, an anti-coagulant manufacturer.

During his presentation, Brown noted that six of the seven members of the ACCP guideline drafting committee reported having a relationship with Sanofi-Aventis, but Jack Hirsh, who chaired the committee that wrote the current edition of the guidelines, downplayed any potential conflict of interest.

“It's probably impossible to get opinion leaders who have not had some interaction with the industry,” said Hirsh, a professor emeritus in the Department of Medicine at McMaster University in Hamilton, Ontario, and the founding director of its Henderson Research Centre. He said that conflicts were managed by “having people arbitrate who don't have these conflicts,” adding that the committee's work was reviewed by a 90-member panel of experts, which included orthopedic surgeons.

Hirsh was critical of American Academy of Orthopaedic Surgeons guidelines calling for the use of aspirin, saying they were based on small cohort studies that are not as solid as large randomized studies. He said what's needed is a randomized study with some 20,000 patients using the various protocols called for under the competing guidelines.

"I think if we did that study, the whole controversy would be finished," Hirsh said, and it would avoid the social cost of having a controversy where different segments of the medical community are "taking sides and throwing stones." Hirsh said that the Duke Clinical Research Institute was hosting a conference on VTE prevention in high-risk groups May 27 in Pentagon City, Va., where he'll promote further research.

Greg Maynard, chief of hospital medicine, at the University of California at San Diego agreed that could be a good idea. He said that "these incidents come up where there is imperfect evidence."

Maynard said that Brown represents a large faction but he felt theirs was not a majority opinion among orthopedic surgeons, so—instead of trying to force opponents into the prophylactic prescribing camp—he said a hospital must work around them.

"I tell people working with orthopedic surgeons, 'If there's too big of an outcry, carve them out; don't allow them to stop prophylaxis for the rest of the hospital,' " Maynard said. "Here's what I think: It's best to have a universal protocol, but if you can't have a universal protocol, go around them—and monitor their outcomes. Don't let wanting to have the perfect universal protocol get in the way of a protocol that works for most people. A protocol that works for the majority is better than the current practice, which is to have no protocol at all or 30 different protocols."

### What do you think?

Write us with your comments. Via e-mail, it's [mhletters@crain.com](mailto:mhletters@crain.com); by fax, 312-280-3183.

### Related Articles

[Belt-tightening time](#)

January 12, 2009

[Small states, big progress](#)

November 24, 2008

---

*Modern Healthcare* is the industry's most trusted, credible and relied-upon news source. In print and online, *Modern Healthcare* examines the most pressing healthcare issues and provides executives with the information they need to make the most informed business decisions and lead their organizations to success. It's for this reason *Modern Healthcare* is deemed a "must-read publication" by the who's who in healthcare.

For more healthcare business news, visit <http://www.ModernHealthcare.com>.