Changes in Medicare reimbursement for hospital-acquired conditions including infections

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As part of the Deficit Reduction Act of 2005, Congress required the Secretary of Health and Human Services (HHS) to identify conditions that (1) are high cost or high volume or both, (2) result in the assignment of a case to a diagnosis-related group that has a higher payment when present as a secondary diagnosis, and (3) could reasonably have been prevented through the application of evidence-based guidelines. For the conditions identified and discharges occurring on or after October 1, 2008, hospitals do not receive additional payment for cases in which one of the selected conditions was not present on admission (POA). That is, the case would be paid as though the secondary diagnosis were not present. The US Centers for Medicare and Medicaid Services (CMS) prohibits the hospital from billing the beneficiary for the difference between the lower and higher payment rates. Rather, the hospital is being encouraged to prevent an adverse event and improve the quality of care it is giving to Medicare patients. There are 6 categories of hospital-acquired conditions that were identified by CMS, 3 of which were related to health care-associated infections: (1) selected surgical site infections, (2) vascular catheter-associated infections, and (3) catheter-associated urinary tract infections. The other 3 categories are (1) serious preventable events (e.g., object left in during surgery), (2) pressure ulcers, and (3) falls and trauma. Additionally, conditions being considered for fiscal year 2009 include ventilator-associated pneumonia, Staphylococcus aureus septicemia, and deep vein thrombosis/pulmonary embolism.

Hospital-acquired conditions will be identified using administrative billing data and to assist in the process hospitals are now required to include a POA indicator code for secondary diagnoses. Identification of health care-associated infections has been notoriously poor using administrative data.\(^1\,^2\) However, CMS hopes the use of the POA codes will increase the reliability and validity of this method.

Whereas this new reimbursement policy is currently limited to Medicare patients, other insurers may follow suit. This is a radical change in reimbursement, which may result in a variety of practice changes. The first and most positive is that hospitals react as CMS hopes and find ways to improve processes and decrease health care-associated infections. The second is that there is no real change in the infection rate; in this case, hospitals may lose the incremental revenues or just change coding practices.\(^3\) The third and least positive response is that the policy results in perverse incentives for hospitals to engage in processes that are not in the patients’ best interest but protect the hospital. Clearly, the impact of this policy on practice needs to be evaluated.

It is important for infection preventionists to be informed about this important policy even though the day-to-day clinical surveillance does not change. Infection preventionists should use this signal from HHS as an opportunity to reinforce the importance of their work to senior hospital administrators. Indeed, HHS has identified reducing preventable health care-associated infections nationally as an important component...
of achieving its mission and vision, with the goal of building a safer, more affordable health care system for all Americans.4

References

