CMS Policy to reduce hospital-acquired conditions had minimal impact

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Hospitals may have avoided financial penalties by billing hospital-associated conditions (HAC) as present at the time of the patient's admission, supporting prior work that showed that a Medicare policy designed to monetarily penalize hospitals for preventable complications had an insignificant impact on reducing healthcare-associated infections. The new research was published today in *Infection Control & Hospital Epidemiology*, the journal of the Society for Healthcare Epidemiology of America. In addition, the targeted billing codes were rarely used by hospitals, far less than expected based on national estimates; and even when hospitals billed for HACs during a hospitalization, this infrequently affected the diagnosis-related group (DRG) assignment, impacting hospital reimbursement.

"With this policy, CMS was hoping to see more attention paid to improving quality care, but it appears that the original HAC policy mostly led to changes in coding practices," said Michael S. Calderwood, MD, MPH, regional hospital epidemiologist at Dartmouth-Hitchcock Medical Center and lead author of the study. "It's worth further investigation to determine whether Medicare reimbursement codes are being incorrectly used, or if there is now a greater effort to document conditions at the time of the patient's admission."

In 2008, the Centers for Medicare & Medicaid Services' (CMS) Hospital Inpatient Prospective Payment System ceased reimbursement for HACs not present on admission (POA) - putting the cost of infections acquired in a health system on the provider—with the intent to encourage hospitals to adopt or strengthen infection prevention measures. Prior research discovered that this change in policy did not have an impact on rates of HACs—rather, providers were coding these HACs as present on admission.

To understand why this trend was happening, researchers analyzed over 65 million Medicare fee-for-service hospitalizations from 2007 to 2011 in acute care facilities. They specifically looked at documentation for central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) and whether the codes for those HACs were submitted with a POA designation, which are not counted against a hospital as a preventable complication.

They found that CLABSI and CAUTI affected 0.23 percent and 0.06 percent of hospitalizations, respectively, and in the three years immediately after the 2008 CMS policy implementation, 82 percent of the CLABSI codes and 91 percent of CAUTI codes were marked as POA—which researchers noted was a significant increase in the use of the present-on-admission designation compared with prior to the CMS HAC Policy.

Diagnosis coding for CAUTI and CLABSI that was not present on admission (POA=No) from 2007 to 2011 showed a dramatic decrease. For example, in 2007 hospitals discharged 6,172 patients with a CAUTI diagnosis code, 99.8 percent of whom had a POA=No designation. This compares to 2011 when 6,448 patients were coded as having a CAUTI, only 10.7 percent of whom had the POA=No designation.

For discharges that were subject to penalty, there was a financial impact on only 0.4 percent of the hospitalizations with a CLABSI code and 5.7 percent with a CAUTI code. These penalties infrequently impacted hospital reimbursement and the researchers suggest that this is partly to blame for the lack of impact from the policy.

More information: Michael S. Calderwood et al, Centers for medicare and medicaid services hospital-acquired conditions policy for central line-associated bloodstream infection (CLABSI) and cather-associated urinary tract infection (CAUTI) shows minimal impact on hospital reimbursement,

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