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CMS Reimbursement Changes Increase Hospital Focus on Infection

By: CINDY SANDERS

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Change is coming, and for those who are unprepared, it could prove to be costly.

Beginning Oct. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will no longer provide reimbursement over and above the typical Inpatient Prospective Payment System (IPPS) rate for care required to battle several types of healthcare-associated infection, also referred to as hospital acquired infection (HAI).

CMS collaborated with the Centers for Disease Control and Prevention and other healthcare groups to identify a number of hospital-acquired conditions that were high volume, high cost, or both and "could reasonably have been prevented through the application of evidence-based guidelines," as mandated by Section 5001(c) of the Deficit Reduction Act.

The final rule states, hospitals "will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present." Those "selected conditions" include:

• Serious preventable events, such as an object left in during surgery, air embolism and blood incompatibility;

• Catheter-associated urinary tract infection;

• Pressure ulcers;

• Vascular catheter-associated infection;

• Surgical site infection –– mediastinitis after coronary artery bypass graft; and

• Falls and trauma including fractures, dislocations, intracranial injuries, crushing injuries and burns.

To distinguish between infections or conditions already present on admission (POA) from those acquired during the hospital stay, the IPPS final rule also required hospitals to begin reporting POA conditions this past October.

Beginning this month, CMS will process that data and give IPPS hospitals feedback on any reporting errors. Between Jan. 1. and March 31, affected hospitals will have a grace period where CMS will educate them on correcting mistakes and not penalize the hospitals for errors. However, starting April 1, any claim submitted for payment that doesn't include proper POA indicator reporting will be returned without payment.

The loss of revenue as a result of an HAI is expected to be costly. In the September 2006 analysis of 1.69 million admissions from 77 hospitals, MedMined Inc. (now Cardinal Health) found that patients with HAIs reduced overall net inpatient margins by $286 million.

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Outsourcing, an Increasingly Attractive Option

Michele and Charles Lee, founders of Lee Medical®, have spent the past 15 years crafting and perfecting a business model that greatly reduces the incidence of HAI as a result of vascular access. Their company, one of the first of its kind in the nation, has introduced major cost savings for providers while ensuring patients receive the best evidence-based care possible.

The two primary initiatives of the company are "source control" and using "the right device at the right time," said company president Michele Lee, RN, CRNI, a vascular access expert. "The full implementation of these two strategies results in cost savings equaling millions of dollars annually for healthcare facilities in Tennessee."

Today, Lee Medical employs specially trained nurses to provide vascular access services and device surveillance around the

clock at facilities across the continuum of care. One of their primary functions is to place and maintain peripherally inserted central catheters. The proper use of PICC lines is a major way to reduce vascular access catheter infections- one of the “selected conditions” singled out by CMS.

Michele Lee pointed out a significant number of patients rely on vascular access devices, like PICC lines, to deliver needed medication.

“One challenge is that the line has to be placed and maintained in a specific manner, or it has a potential to cause a catheter-related bloodstream infection (CRBSI),” she said.

She added that CRBSI, along with ventilator-associated pneumonia (which CMS is considering adding to the “selected conditions” list for FY2009), are the two most costly infections to treat.

“The average cost to treat a CRBSI is $91,000 … that’s the average,” she pointed out. “Currently, the average reimbursement is about $67,000 – an operational loss of $24,000. As of Oct. 1, 2008, reimbursement will be zero. Obviously, this negative financial impact will quickly erode the provider’s bottom line.”

The CDC estimates 250,000 central line-associated infections occur in the United States annually with an attributable mortality rate of 12 to 25 percent.

With the changes to the CMS reimbursement rules, the Lees said they are finding hospitals are more open to innovative approaches to reduce infection rates.

“One of several keys to infection control,” noted Charles Lee, company CEO, “is the continuity provided by the same nurse maintaining the line in a regimented discipline. LMI provides that continuity for the patient as they transfer across the continuum of care. The patients and their vascular access devices are tracked concurrently using our proprietary electronic medical data software, VAST™.”

He added that today’s staff nurses have an overwhelming workload, which prevents them from attaining an acceptable level of expertise in vascular access. By comparison, Lee Medical’s nurses are required to perform 250 procedures during their initial orientation period. The national standard, said Charles Lee, is “three procedures and then you’re considered PICC qualified.”

The combination of rotating shift nurses handling the line, a lack of continuity, compliance and/or coordination in maintenance protocols, and juggling too many patients with too little time is a recipe for an inadvertent mistake leading to infection.

“We go in and virtually eliminate these variables for hospitals because of the level of expertise and continuity that we are able to provide,” he said.

Michele Lee added: “The bottom line is source control to prevent bacteria from attaching to intraluminal and extraluminal surfaces, as well as achieving clinical competence and adhering to very regimented standards of practice that lead to predictable and replicable outcomes.”

Lee Medical has a track record of less than 0.5 infections per 1,000 catheter days as compared to many hospitals that report CRBSI infection rates between 2 and 10 percent. By reducing a 700-bed hospital’s CRBSI rate from 4.6 percent to less than 0.5 per 1,000 catheter days, the cost savings associated with treatment alone is nearly $26 million annually.

“Our phone is currently ringing off the hook because of what’s coming with reimbursement cuts,” Michele Lee said, adding the growth is such that the Franklin-based company will soon move beyond Middle Tennessee to cover the entire southeastern region.

“When we started 15 years ago,” Charles Lee recalled. “It was just individual contracts, but now health systems are starting to approach us and say ‘this is a systemic problem we need help with.’ We have a breakthrough value proposition for healthcare that is at last being recognized as such due to the influence of certain undeniable market forces.”

Whether hospitals choose to set up or reinforce in-house protocols or opt to use outsourced experts, the countdown has begun to get major HAI rates under control or face the bottom line consequences.

FYI from CMS

For the latest information on the pending changes, go online to www.cms.hhs.gov/HospitalAcqCond. The Web site includes information on the statute, educational resources, coding, conditions selected for financial implication and those under review, and reporting requirements.

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By: **Nemai** on 10/10/11

Politicians have always batted around how Medicare payments are determined. There are currently 441 geographic payment zones for hospitals that pay on the basis of general costs in the region. Hospitals with better patient-care results will be seeing a change soon. In 2013, hospitals will get greater bills for greater patient-care outcomes. The fact is Quality-based Medicare payments could hurt minority patients .

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