Limited Impact of 'No Pay' Rule

CAUTIs *from page 1*

But in order to trigger nonpayment under the CMS policy, the claim must include both a diagnostic code (ICD-9-CM) for urinary tract infection and the catheter-association code 996.64, and the UTI diagnosis must be listed as not present on admission, thereby denoting that it was hospital acquired. If the hospital doesn't assign the accurate diagnosis codes, the hospital receives payment for the UTI by default. Also, payment is made if a patient has one or more comorbidities that increase the likelihood of catheterization and/or a UTI (Ann. Intern. Med. 2009;150:877-84).

The study was an analysis of data from the 2007 Healthcare Cost and Utilization Project State Inpatient Database, which includes administrative discharge data for all payers from all acute care, nonfederal hospitals in Michigan. The study population included all adults hospitalized for more than 1 day, except for those admitted for labor and delivery. A total of 144 hospitals with more than 250 annual adult discharges were included.

Overall, the proportion of discharges coded for a secondary diagnosis of non–catheter-associated UTI ranged from 2% to 38%, with a mean of 10.5% and a mode of 9.0%. In contrast, the percentage of discharges with a secondary diagnosis using the catheter-association code 996.64 were far lower, ranging from 0 to 2.3% of discharges, with a mean of 0.11% and a mode of 0.04%.

Of note, 44 hospitals (30.5%) did not use the catheter-association code for any discharge, despite a mean UTI rate of 9.6%, while 94 hospitals (65.3%) requested payment for fewer than 5 cases of CAUTI as a secondary diagnosis. "Rare use of the catheter code 996.64 in contrast to high rates of secondary diagnosis UTIs suggests that many CAUTIs may be misidentified as non–catheter-associated UTIs in claims data submitted for payment," Dr. Meddings said.

Of the total 999,962 adult discharges in Michigan in 2007, 9.4% had a secondary diagnosis of non–catheter-associated UTI, while just 0.09% had a secondary diagnosis of CAUTI.

Comorbid conditions were more frequently associated with both UTI and CAUTI. For example, diabetes was present in 25% of all discharges, in 32% of those diagnosed with a secondary non–catheter-associated UTI, and in 39% of those with a secondary CAUTI. Renal failure was diagnosed in 11% overall, 18% of those with UTI, and 20% with CAUTI, and heart failure in 10%, 20%, and 26%, respectively. Because of the patients' comorbidities, these discharges would garner the additional payment whether the UTI was catheter associated or not, she noted.

Dr. Meddings concurred with an audience member who pointed out that catheter use is usually documented in nursing notes, but not often in physician notes. Often, the physician may not be aware that the patient has a catheter. If coders see something in the nursing notes that is pertinent to the diagnostic coding, federal law requires them to ask the provider if the diagnosis is correct. Then the provider must submit an addendum to the medical record to reflect the diagnosis before the code may be used. "Needless to say, this is an extra step with extra work," Dr. Meddings said in a follow-up interview.

No public data are available to gauge the impact of the CMS policy on use of the catheter code. Dr. Meddings' group is just starting to analyze such data from their own institution."I hypothesize it may be used less, because many coders have informed me that they are only obligated to list secondary diagnoses that are required to justify the requested hospital payment. Since the hospital-acquired CAUTIs no longer increase payment, there is less incentive for the hospital coder to go through the extra steps needed to document a hospital-acquired CAUTI," she said. ■

Disclosures: *The study was funded by the Blue Cross/Blue Shield of Michigan Foundation. Dr. Meddings and her coinvestigators had no relevant disclosures.*

MY TAKE

Keep the Focus on Quality of Care

The goal of the CMS value-based purchasing initiative is simple: Reduce health care costs by no longer providing additional financial compensation for common and reasonably preventable hospital complications. Because hospitals will no longer receive compensation for these complications, there is an indirect incentive to implement preventive measures.

The "no pay" policy for hospital-acquired, catheter-associated urinary tract infection (CAUTI) is one such example. The policy seems straightforward, but the practical implementation is cumbersome and complex, carries a risk of shifting opportunity costs, and may not have the intended financial impact, as illustrated by the findings reported by Dr. Meddings and her colleagues.

As hospital-based clinicians, we should remain steadfast in aiming to deliver the highest-quality evidence-based care. With regard to CAUTI, bundled interventions that limit catheter placement to appropriate patients, increase the awareness of catheter presence, and prompt the removal of catheters as soon as feasible are simple measures that will directly benefit our patients.

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Survey: 68% of Hospitals Join in Infection-Control Efforts

BY MIRIAM E. TUCKER

ATLANTA — Between 2005 and 2009 there were significant increases in the use of some—but not all—recommended infection-prevention practices, according to survey results from 600 U.S. hospitals.

On Oct. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) stopped reimbursing U.S. hospitals for the additional cost of certain infections deemed to be preventable. At least 20% of all health care–associated infections (HAIs) are believed to be preventable, with estimates for specific types of infections ranging from 10% to 70%, Sarah L. Krein, Ph.D., said at the Decennial International Conference on Healthcare-Associated Infections.

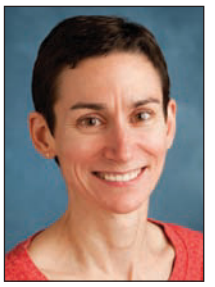
VITALS

Major Finding: Between 2005 and 2009, the proportion of hospitals that participate in a state or regional collaborative effort to reduce hospital-acquired infections jumped from 42% to 68%.

Data Source: Survey of 600 randomly selected U.S. hospitals.

Disclosures: Study was funded by the Department of Veterans Affairs, the National Institute of Nursing Research, and the Blue Cross/Blue Shield Foundation of Michigan. Dr. Krein stated that she had nothing to disclose.

"We're making progress, but effectively translating recommended infection-prevention practices into clinical settings remains a challenge," said Dr. Krein, who is a registered nurse and a research associate professor at the University of Michigan, Ann Arbor, and the VA Ann Arbor Healthcare System.



The study sought to determine the impact of the CMS rule by surveying infection preventionists at 600 randomly selected U.S. hospitals with more than 50 beds in March 2005 and again in March 2009. The response rate was about 70% for both years.

From 2005 to 2009, the proportion of hospitals that have hospitalist physicians increased from 57% to 75%, and the proportion that participate in a state or regional collaborative effort to reduce HAIs jumped from 42% to 68%.

Respondents were asked how frequently a specific practice was used for hospitalized adults on a scale of 1-5. The practices were all included in recent recommendations by the Centers for Disease Control and Prevention, the Infectious Diseases Society of America, the Society for Healthcare Epidemiology of America, and the Association for Professionals in Infection Control and Epidemiology. The analysis was weighted so that the results represent the population of U.S. hospitals from which the initial sample was selected.

In both years, practices aimed at reducing central line–associated bloodstream infection (CLABSI) and ventilator-associated pneumonia (VAP) were implemented more often than those targeting catheter-associated urinary tract infection (CAUTI), even though the CMS nonpayment rule applies to CAUTI but not yet to VAP or CLABSI.

Most practices were aimed at reducing central line infections and ventilator-asociated pneumonia.

DR. KREIN

For CLABSI prevention, there were significant increases between 2005 and 2009 in those reporting "almost always" or "always" using maximum sterile barriers (71% to 90%), chlorhexidine as a site disinfectant (69% to 95%), and antimicrobial dressing (25% to 54%).

With regard to VAP, there were moderate increases in use of semirecumbent positioning (82% to 95%) and antimicrobial mouth rinse (41% to 58%), with a more dramatic increase in use of subglottic secretion drainage (21% to 42%).

For CAUTI, there were slight increases in use of bladder ultrasound (29% to 39%) and antimicrobial urinary catheters (30% to 45%) and a more dramatic increase in use of reminders/stop orders (9% to 20%).

Respondents were also asked for their perception of the effect of the CMS payment change on the importance of preventing the three types of infections. Those reporting a "moderate" or "large" increase in importance were 58% for CLABSI, 54% for VAP, and 65% for CAUTI, a finding that is "noteworthy, considering the data," Dr. Krein commented.

She noted that CAUTI prevention practices in particular require both additional evidence to support their use and more effective strategies to facilitate their implementation.

CAUTI was not considered as high a priority by hospital staff, despite the fact that it is included in the CMS nonpayment rule while VAP and CLABSI are not, she said: "UTIs are still viewed as benign in many cases." ■