CMS POLICY WILL REFORM REIMBURSEMENT OF EIGHT HOSPITAL ACQUIRED CONDITIONS

Background

The Deficit Reduction Act of 2005 mandated the Secretary of Health and Human Services to select at least two medical conditions that were: 1. high cost/volume or both 2. as a secondary diagnosis were responsible for reassignment of a patient to a higher paying DRG and 3. could have "reasonably" been prevented.[1] Exceeding the legislative minimum, the Secretary selected eight. In May of 2007, the Centers for Medicare and Medicaid Services (CMS) announced those diagnoses: post surgical retained equipment, air emboli, blood incompatibility reactions, urinary catheter-associated infections (UCAI's), vascular catheter associated infections (VCAI's), pressure ulcers (PU's), post coronary artery bypass graft (CABG) mediastinitis. This reform has the potential to reduce hospital revenue from inpatient admissions and encourage incidence reduction of hospital acquired conditions (HAC).

POA Details and Requirements

Several components of the IPPS reform are important for UNC Healthcare. Fist, CMS is requiring coders to specify POA designation for all diagnoses. After April 1 2008, CMS will remit claims without POA coding. Next, after October 1, 2008, CMS is will no longer reimburse hospitals "additional payments" for these eight hospital acquired conditions when they: 1. demand a higher DRG and 2. were not documented present on admission (POA).

To comply with CMS, UNCH physicians must document whether diagnoses are POA or HAC. POA is defined as "present at the time the order for inpatient admission occurs".[2] Conditions that begin in the emergency room, outpatient surgery or during observation are therefore POA. Coders will describe secondary diagnoses as Y-POA (present), N-POA (not present), U-POA (undetermined from documentation), W-POA (clinically undetermined). From our interpretation of CMS literature, only Y-POA cases will always be reimbursed and only physician documentation can be used to specify POA vs HAC.

Internal Review

UNCH quality analysts (Franklin Farmer and Lauren Romano) and coding specialist (Theresa Sober) have performed two analyses to estimate the system exposure to the POA/HAC reimbursement reform. A hospital-level survey of diagnoses found that blood incompatibility, CABG mediastinitis, air emboli and retained objects are rare and that falls, UCAI, VCAI and PU have a significant frequency. From a three month consecutive case review, it appears that HA pressure ulcers occur at a significant volume and incur a significant cost.

Pressure Ulcer Burden and Prevention

Pressure ulcers develop at bony sites where sustained pressure results in compromised perfusion, ischemia and necrosis.[3] Low grade ulcers can appear in as few as two hours.[4] As many as 3 million adults have at least one pressure ulcer; treatment is estimated to cost from $500-70,000 per ulcer.[5] The United States spends an estimated $11 billion dollars per year on PU's, 60% of which begin during acute care admissions.[6] Daily skin assessments, maximized nutrition and repositioning are key strategies in published guidelines and hospital protocols for PU prevention.[7,8] UNC nursing staff have produced remarkable success with daily skin examinations and risk assessment. The incidence of PU in our hospitals has decreased from 6.1% to 3.9% between May 2007 and March 2008. Still, with the CMS reform, physician involvement in admission skin assessment and PU care is imperative.

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[1] CMS. "Medicare Program; Proposed Changes to Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008". Federal Register. Vol72.No85.200

[2] CMS. Present of Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hosptials. Medicare Learning Network. December 2007. http://www.cms.hhs.gov/hosptialacqcond/

[3] V Dini M Bertone M Romanelli. Prevention and management of pressure ulcers. Dermatologic Therapy, Vol. 19, 2006, 356–364

[4] Reddy M;. Gill S; Rochon PA. Preventing Pressure Ulcers: A Systematic Review. *JAMA*. 2006;296(8):974-984.

[5] Reddy M;. Gill S; Rochon PA. Preventing Pressure Ulcers: A Systematic Review. *JAMA*. 2006;296(8):974-984

[6] Kuhn BA. Balancing the pressure ulcer cost and quality equation. Nurs Econ. 1992; 10:353-359.

[7] Bergstrom N, Allman RM, Carlson CE, et al. *Clinical Practice Guideline Number 3:* Pressure Ulcers *in Adults: Prediction* and Prevention*.* Rockville, Md: Public Health Service, US Dept of Health and Human Services; 1992

[8] Cuddigan J, ed, Ayello EA, ed, Sussman C, ed, Baranoski S, ed. *Pressure Ulcers in America: Prevalence, Incidence, and Implications for the Future.* Reston, Va: National Pressure Ulcer Advisory Panel; 2001

Implications and Future Direction

This policy is a dramatic shift from paying more for high quality care to withholding payment for low quality care.[9] It is, however, aligned with CMS previous demonstrations of "value-based purchasing". These eight diagnoses are only the *first* eight POA-HAC diagnoses. CMS has described five additional conditions that are expected to be added in FY2009. UNC Healthcare must maintain a two-pronged response to the CMS POA-HAC reform: 1. Optimized documentation of POA diagnoses and 2.continued vigilant provision of high quality, evidence based care.

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[9] Rosenthal, Meredith B.
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