



PROFESSION

Medicare's no-pay rule sharpens infection-control efforts

With financial penalties on the line, hospital leaders and staffers are paying more attention to safety protocols.

By KEVIN B. O'REILLY, *amednews staff*. Posted May 14, 2012.

The 2008 "no-pay" rule adopted by the Centers for Medicare & Medicaid Services to encourage hospitals to stop medical complications has led to consistently funded infection control departments, more collaboration with physicians and other front-line staff, and higher compliance with evidence-based guidelines.

More than 80% of infection-control professionals believe the CMS policy has led to greater focus on the health care-associated infections targeted under the rule, said a study published in the *May American Journal of Infection Control*. The study reported results of a survey of 317 infection preventionists at a nationally and industrially representative sample of hospitals. The journal is published by the 14,000-member Assn. for Professionals in Infection Control and Epidemiology.

Of the 10 categories of hospital-acquired conditions targeted by the Medicare policy, three of the biggest encompass infections linked to surgical procedures, central venous catheters and urinary catheters. Under the rule, CMS denies payment to hospitals for the extra cost involved in treating a Medicare patient who is diagnosed with one of these conditions during a hospital stay that was not documented upon admission. Physician pay is not directly affected.

Nearly 70% of infection-professionals said that, since the CMS policy, they are spending more time educating staffers on best practices to prevent central line associated-bloodstream infections and catheter-associated urinary tract infections. About one-third said they also are devoting more time to education on preventing mediastinitis after coronary artery bypass graft, another infection targeted by the no-pay rule.

"The CMS policy really shone a light on infection prevention and allowed folks to have a better awareness of prevention work in the hospital and recognition of that by hospital leadership and staff," said Grace M. Lee, MD, MPH, the study's lead author and associate medical director of infection control at Children's Hospital Boston. "Infection preventionists felt like it gave them some credibility to make sure they got the collaborative support of their peers."

Teaming together to fight infections

There is only so much infection control departments alone can do to prevent infections. That is why collaboration with staffers and quality improvement departments is critical, said Linda Greene, RN, director of infection prevention at University of Rochester Medical Center in New York.

"We're kind of like the coach on the team. Unless people on the front lines — from the senior leadership on down — are engaged, we're not going to get where we want to go in terms of preventing infections," said Greene, secretary of the APIC board of directors.

That recognition is reflected in the dollars devoted to infection control departments. Even amid a recession that has led to many hospital layoffs, only 6% of respondents reported lower funding for their infection control program since 2008. Fifteen percent reported bigger budgets, and about three-quarters said budgets have remained stable.

More face time with doctors and other staff and more education may be having an effect on clinical practice. One of the keys to reducing central-line infections and UTIs is to remove catheters as soon as clinically appropriate, because the longer they are in place, the greater the odds of infection. More than 70% of infection preventionists said urinary catheters are being taken out earlier, and half said the same is true for central venous catheters.

In April, the Dept. of Health and Human Services reported that the rate of central-line associated bloodstream infections has dropped 33% since 2008, while surgical-site infections declined by 10% and catheter-associated urinary tract infections fell 7%. It is unclear how much of this progress can be attributed to the CMS policy, because voluntary nationwide quality initiatives have been under way during this period. Dr. Lee and her colleagues are conducting further research to isolate the impact of the no-pay rule on infection rates.

The study did suggest some unintended consequences of the CMS policy. A third of the respondents said they are devoting less time to work preventing infections not covered by the no-pay rule, and about half said they are spending more time working with physicians and billing staff to properly document and code any infections that are present upon admission to avoid the nonpayment penalty.

In another administrative effort to document infections present upon admission, 27% of infection professionals said their hospital routinely obtains urine cultures from all patients with urinary catheters when they are admitted. Thirteen percent said their hospital does blood cultures for all patients admitted with a central venous catheter. Such testing, when it is not in response to signs and symptoms, could lead to false positives and misprescribing of antibiotics that can give rise to infections such as *Clostridium difficile*, experts said.

“We only want to be doing tests when they are clinically indicated,” said Dr. Lee, associate professor of population medicine and pediatrics at Harvard Medical School in Boston.

APIC favors using the Centers for Disease Control and Prevention’s National Healthcare Safety Network reporting system instead of Medicare billing information, which it says contributes to unneeded testing and is less accurate. Even with strict adherence to safety protocols, not every infection can be prevented, APIC’s Greene said. She added that hospital infections should not be placed in the same nonpayment category as so-called never events such as wrong-site surgery.

The American Medical Association has voiced similar concerns about several of the conditions included in the no-pay list.

ADDITIONAL INFORMATION:

How the no-pay rule affects infection control

Infection-control professionals nationwide say Medicare’s 2008 rule denying extra payment for treating “reasonably preventable” hospital-acquired conditions, such as infections, has made an impact on their work.

Outcome	Those seeing impact
Infection-control program funding same or higher	92%
Greater focus on infections targeted by CMS policy	81%
Greater interdisciplinary collaboration	65%
More face-to-face time with front-line staff	57%
Closer work relationship with quality improvement professionals	57%

Source: “Perceived impact of the Medicare policy to adjust payment for health care-associated infections,” *American Journal of Infection Control*, May (ncbi.nlm.nih.gov/pubmed/22541855/)

WEBLINK

“Perceived impact of the Medicare policy to adjust payment for health care-associated infections,” *American Journal of Infection Control*, May (www.ncbi.nlm.nih.gov/pubmed/22541855/)

Medicare’s “no-pay” list of hospital-acquired conditions (www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/hospital-acquired_conditions.html)

Copyright 2012 American Medical Association. All rights reserved.

RELATED CONTENT

- » Medicare's no-pay rule has little financial impact Oct. 26, 2009
- » Final Medicare no-pay rule targets 10 hospital-acquired conditions Aug. 25, 2008
- » Medicare's no-pay events: Coping with the complications July 14, 2008
- » No pay for "never event" errors becoming standard Jan. 7, 2008