

PROFESSION

No pay for UTIs has little effect on hospitals' bottom lines

Catheter-related infections acquired during hospital stays frequently go unnoted by coders.

By **KEVIN B. O'REILLY**, *amednews* staff. *Posted Sept. 18, 2012.*

Medicare's 2008 policy of denying extra payment for catheter-associated urinary tract infections is having virtually no impact on hospital finances, suggests a study published Sept. 4 in *Annals of Internal Medicine*.

Researchers examined rates of catheter-related UTIs in 96 acute-care Michigan hospitals in the year before and the year after Medicare's policy was implemented. They looked to see how often the infections were documented and coded and would lower hospital payment.

Ten percent of discharges included a request for payment for other kinds of UTIs. Yet nonpayment for hospital-acquired catheter-associated UTIs resulted in lower pay in only 25 cases of the nearly 800,000 hospitalizations examined. That would add up to \$132,675 less pay for all 96 hospitals — less than \$1,400 per hospital — during a one-year period, said the study (ncbi.nlm.nih.gov/pubmed/22944872).

The finding is surprising, because catheter-related UTIs are common and difficult to prevent. About a quarter of hospital patients have a urinary catheter in place at some point during their stays. There are about 500,000 catheter-related UTIs annually, and they account for nearly a third of hospital-acquired infections, according to the Centers for Disease Control and Prevention.

The reason for the no-pay rule's lack of financial impact is how it is administered, said Jennifer A. Meddings, MD, lead author of the study. Instead of relying on infection surveillance data or medical records, the rule is based on claims data submitted by hospitals.

"We're not saying the coders aren't following the rules," said Dr. Meddings, an assistant professor of internal medicine at the University of Michigan Medical School. "There's no evidence that they're not following the rules, because it's a billing data set, and certain rules have been in place for a long time to guide how that data set gets put together. Those rules weren't altered or done any differently when the data was done for something besides billing, which is tracking complication rates."

Weakness of claims data

Coders are supposed to note diagnoses that are likeliest to affect patient mortality and morbidity and justify continued hospital treatment, Dr. Meddings said. For the patients who had a catheter-related UTI, hospitals listed an average of 19 secondary diagnoses per patient, the study found. Also, catheter use is often documented in nursing notes but not in physician notes, and coders can only use doctors' notes in preparing claims.

In an earlier study, Dr. Meddings and her colleagues examined 80 randomly selected discharges. Coders did not identify any hospital-acquired catheter-associated UTIs, while physicians who reviewed the same records identified 36 cases of such infections.

Starting in 2015, hospitals that have the worst rates of hospital-acquired conditions such as catheter-related UTIs, pressure ulcers and surgical site infections will see their Medicare pay lowered. The use of claims data to track infections should be improved, or Medicare should move toward using infection surveillance data submitted to the CDC's National Healthcare Safety Network, Dr. Meddings said.

"The no-pay policy was well-intended ... but this was implemented with a data set that was never tested for that purpose," she said. "If you're using a data set that's not designed to measure the event, then it's not likely to get the desired impact. We're worried it may lead to penalizing hospitals that are working hard and documenting well simply because they're coding well. That's an important unintended consequence."

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