



THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

VOL. 104 No. 7

JANUARY 2008

THE BLAME GAME

*Description and Evaluation of Medicare's
Hospital-Acquired Conditions Provision*

THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

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This month, the *Journal* brings you a look at the Centers for Medicare and Medicaid's (CMS) much-publicized rule that, once implemented, will block payment for certain hospital-acquired conditions. What is CMS' rationale for the new rule? What response is it generating from local and regional health care providers? It's a hot topic, and it's all here in our cover story on page 150.

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THE BLAME GAME

Description and Evaluation of Medicare's Hospital-Acquired Conditions Provision

During one of many well-known "Seinfeld" episodes, the show's goofy, high-haired *Kramer* observes a splenectomy with main character *Jerry Seinfeld*. While watching from above the operating room, *Kramer* eats Junior Mints® and he offers one to *Jerry*. As appetizing as candy sounds in the midst of a bloody operating scene, *Jerry* refuses the candy. Aghast, *Kramer* persists. Finally, the mint is dropped ... right into the open wound of the patient below. The patient is then sewn up – mint and all – and ultimately recovers without permanent harm done.

An object left inside a body after surgery – particularly a "Junior Mint" – makes for funny television. After all, the doctor didn't do it, the patient recovered, and there was no extra cost for the insurer. But what about real hospital-acquired conditions that happen every day during the hospital stay of real patients? There's little humor in that, and it can increase the already high cost of health care.

A large number of preventable errors happen in hospitals across the nation. The Institute of Medicine's 1999 study, "To Err is Human," reported that "more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS

(16,516)." The National Academies reports that nosocomial (hospital-acquired) infections kill nearly 90,000 patients in the United States each year and cost an additional \$5 billion to treat.

Leaving foreign objects inside a body, though it happens, seems like an obvious mistake on the part of the hospital staff, but for other hospital-acquired conditions, it may not be as easy to assign blame. When things like urinary tract infections and bed sores occur during a patient's hospital stay, should the hospital be responsible for paying the costs of associated care of these nosocomial problems? It depends on who you ask. If you're asking Medicare, the answer clearly is "yes," as evidenced by Medicare's new provision blocking payment for several conditions that Medicare deems "reasonably preventable."

The Rule Explained by CMS

In the past, hospital errors and hospital-acquired conditions have been covered by Medicare in cases regarding Medicare-covered patients. However, as you may well have heard by now, The Centers for Medicare and Medicaid Services (CMS) announced in August 2007 that, beginning October 1, 2008, Medicare will no longer **pay more** for eight "reasonably preventable" conditions acquired during hospi-

tal stays. "Pay more" sounds a little confusing, but according to CMS officials, it simply means that, with this rule in effect, Medicare will continue to pay for conditions presents when a patient enters the hospital, but will not pay *more* to cover the cost of conditions they deem caused by the hospital.

The provision, officially titled "The Hospital-Acquired Conditions Provision in the Inpatient Prospective Patients System Fiscal Year 2008 Final Rule," was formed in response to legislative authority (Section 5001C of the Deficit Reduction Act of 2005) according to CMS Spokesperson Thomas Valuck, MD, JD. Specifically, the rule blocks payment for treatment costs related to eight conditions,* when those conditions are not present upon admission.

***The eight conditions for which hospitals may lose reimbursement in the coming year include:**

- objects left in the body after surgery
- in-hospital falls
- mediastinitis
- urinary tract infections that result from improper use of catheters
- pressure ulcers
- vascular infections that result from improper use of catheters
- air embolism
- blood incompatibility

The hospital-acquired condition provision is a CMS value-based purchasing initiative. With the initiative, the organization said its goal is to avoid costs that are above what it has already planned to pay. "CMS is working to transform the Medicare program from passive payer to active purchaser of higher quality, more efficient health care services for our beneficiaries through the application of value-based purchasing principles," said Dr. Valuck. "A value-based purchasing initiative encourages better performance by health care providers through the application of incentives, such as payment incentives and public reporting."

To avoid the listed conditions, CMS recommends that hospitals adhere strictly to evidence-based guidelines and engage their physicians to better document what is and what is not present on admission. The National Academies reports that "wider implementation of the nosocomial infection guidelines from the Centers for Disease Control and Prevention (CDC) would save more than 40,000 lives annually,

reduce infection rates by up to 50 percent, and save nearly \$2.75 billion."

Local and Regional Concerns

The New York Times reported (8/19/07) that the new policy "is sending ripples through the health industry." The Alliance for Academic Internal Medicine, who also covered the release of the new rule, reported a mixed bag of responses. They report

"Less medical care rather than better medical care may be the result."

– Brenda Powell, MD

(8/19/07): "Some observers hail the rule for its potential to force physicians to adhere strictly to clinical guidelines and assess the conditions with which patients arrive at the hospital; however, hospital executives worry that the rule will spike the number of tests patients

receive at admission and increase overall costs for the hospital."

We wanted to know what you think about the new rule. Will it help – or harm – patients? How will it affect hospitals and patient access to care? We spoke with several local and regional health professionals and, though they share some common concerns, each had a unique opinion of CMS' new rule. Your AMS president, Brenda Powell, MD, was among many whose feelings were, at best, mixed. "The latest Medicare rule to block payment for some preventable infections on the surface appears to have merit as an incentive to provide better care," said Dr. Powell. "However, when hospitals and physicians are struggling with low reimbursement from private insurers and Medicare, not to mention growing numbers of uninsured, the effect may be to push some small community hospitals over the edge," said Dr. Powell. "Less medical care rather than better medical care may be the result."

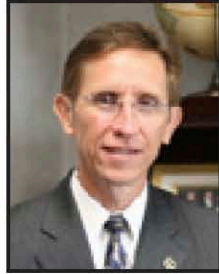
We also spoke to a hospitalist PA who was concerned about conditions

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that can occur even with the best of care. "If a patient has to be in the ICU for five days and consequently develops a sore on the coccyx or heel, it's likely there because the staff didn't turn the patient enough or didn't provide a pressure relief mattress (which costs money)," said the PA, who wished to remain anonymous. "In cases like that, the tax-paying public should not be reimbursing the facility that caused the problem. On the other hand,



Ray Montgomery,
White County
Medical Center

sometimes the facility could do absolutely nothing to have prevented the problem. Maybe the patient is a severely debilitated, malnourished elderly person who would have developed a sore or infection from a poor immune system response or skin too fragile to avoid problems."

Ray Montgomery, President and CEO of Searcy's White County Medical Center, also expressed apprehension about some of the conditions on the list. "If a patient slips and breaks a hip during a hospital stay, is this negligence on the part of the hospital? What if the hospital has educated the patient on fall prevention and has taken appropriate precautionary measures? If the patient does not follow guidelines, the hospital is not at fault and should still be reimbursed," said Montgomery.

Montgomery believes also that simply blocking payment for preventable medical errors won't be as easy as it sounds. He wonders, "Who will make the judgment as to what is preventable and how actual cause will be determined?" In some cases, he says, there may be no way to pinpoint actual cause, particularly of infections. "Patients come in who were exposed to organisms before they arrived. Family members bring it into patient rooms and expose the patient. These cases have no way to target the source."

Arkansas Children's Hospital (ACH) has spent the past seven years focusing on better adherence to CDC guidelines, especially those related to central-venous catheter-related infections.

For its work, the hospital's success has earned national recognition in *The Wall Street Journal* and other national publications. Two of the most significant prevention strategies that worked for ACH include the use of full barrier precautions when inserting catheters and the practice of performing skin preps with chlorhexidine rather than Betadine.

"We also use antibiotic-impregnated catheters," said Steve Schexnayder, MD, professor of Pediatrics and Internal Medicine and chief of Critical Care Medicine for the hospital. "None of these are sufficient in and of themselves, but they are clearly part of a number of things that can be done."

As part of The Critical Care Team that helped the ACH Pediatric Intensive Care Unit reduce its central venous catheter infections four-fold, Dr. Schexnayder feels strongly that hospitals have a responsibility to follow the best evidence – and really, do everything possible – to prevent error. Still, he sees the Medicare provision as ambiguous in its language and maybe even falsely accusatory. Is this law implying that when one of these conditions happens during a patient's hospital stay, the hospital is unequivocally to blame?

"There are certain patient-related factors that predispose some patients to some of these complications," he said. "Clearly, hospitals can do things to reduce the number of hospital-acquired conditions. However, the data is far from clear that 'the hospital' causes these conditions," said Dr. Schexnayder. "For instance, how is 'improper use of catheters' defined? That's fairly vague. I don't think you can always hold health care institutions responsible for their happening."

Regardless of how health care professionals feel about the rule, it is set to go into effect this October. Hospitals have expressed concern about the rule's implementation, a concern that has been voiced by William Golden, MD, professor in the UAMS Colleges of Medicine and Public Health. In the past, Dr. Golden has expressed con-

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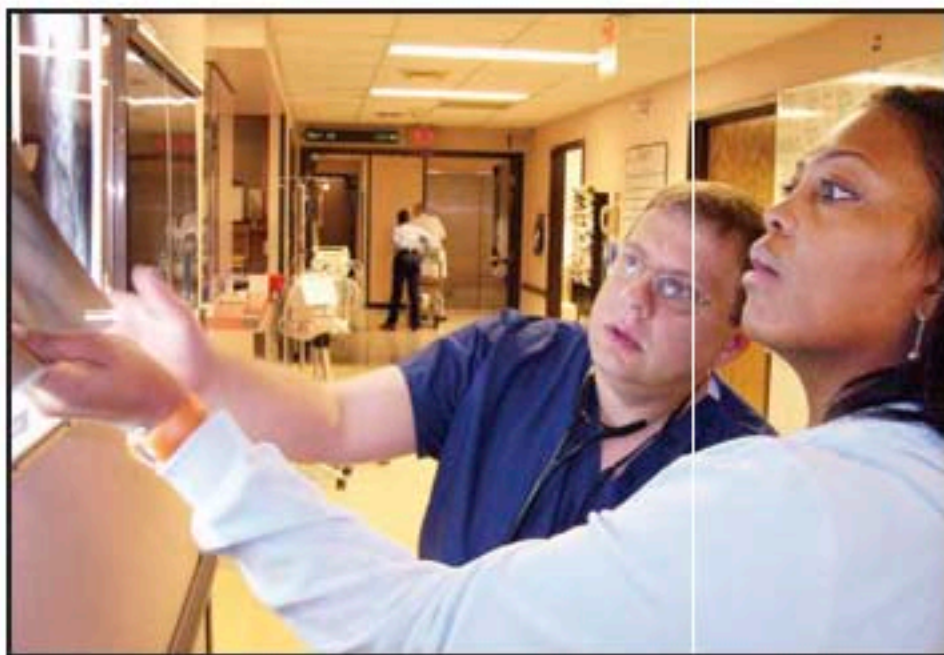
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Dr. Steve Schemayder, Arkansas Children's Hospital – Photo Courtesy of ACH

cern about items on the list and about the rule's potential to limit access to care by high risk patients should related penalties become severe. He isn't as worried today. "I have since learned that the implementation of the program is less than one might think," said Dr. Golden. "The penalty is not a refusal to pay for care, but rather a refusal to allow the billing of a higher weight DRG [Diagnosis Related Group] because of the complication. This is more of a statement of engagement than a burdensome financial program."

"The penalty is not a refusal to pay for care, but rather a refusal to allow the billing of a higher weight DRG [Diagnosis Related Group] because of the complication. This is more of a statement of engagement than a burdensome financial program."

– William Golden, MD

Clearly, some hospitals are worried about the financial burden the rule may produce. The *Wall Street Journal* reported in September 2007 that "Hospitals around the country are scrambling to put new programs in place to prevent pressure ulcers, commonly known as bedsores," since the announcement by CMS. So as to catch anything already there, hospitals may use more detailed and mandatory skin assessments, automatic urine tests and blood cultures on admission.

Does the new CMS rule fail to account for the fragile, unpredictable nature of the human body? Is it a necessary tool to force all physicians to care just a little bit more? A lot is still up in the air about the pending provision, which will likely include additional conditions and guidelines by its October implementation date; however, one – no, two – things are clear: Junior Mints should be kept out of the operating room, and caregivers should, as usual, care for patients as best they can. "Medical staffs, nursing staffs, and hospital administrators must continue working together to improve quality," said Montgomery. "Hospitals have a responsibility to provide quality care for all people in a fiscally cost-efficient manner. We need adequate resources to accomplish our mission: caring for people." **AMS**