Hospital-Acquired Infections: Should Medicare Pay?

The following editorial offers an opinion about a change in Medicare regulations that is addressed in this issue’s reimbursement article, on page 26. The new CMS rule will result in denial of reimbursement to hospitals for certain medical errors and infections acquired by patients while in the hospital. Although, as the author writes, the CMS intent to reduce Medicare costs for preventable infections is laudable, the complexity of this issue intensifies for patients with immune impairments. Whether the new rule has the desired effect of improving patient care will not be known until the rule’s implementation in October and the months that follow.

We encourage patients and providers to track this issue—and we’d like to hear your opinions! Send them to editor@igliving.com.

Medicare Non-Payment for Selected Medical Errors and Nosocomial Infection

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According to new Medicare regulations, which become effective October 1, 2008, hospitals will no longer receive payments for costs associated with certain medical errors or specific hospital-acquired infections. The regulation may be viewed at: www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf. These new rules were designed to provide hospitals with an impetus to improve patient care and reduce cost.

Under rules adopted by the Centers for Medicare and Medicaid Services (CMS), payments to hospitals will be withheld for:

• catheter-associated urinary tract infection
• vascular catheter-associated infection
• mediastinal infection after coronary artery bypass graft surgery
• decubitus ulcer
• hospital-acquired injury, such as a fracture from a fall
• objects left in a patient during surgery
• air embolism
• blood incompatibility

To comply with the Deficit Reduction Act of 2005, CMS evaluated a number of serious, preventable, healthcare-acquired conditions and was charged to select at least two conditions that could reasonably be prevented through adherence to evidence-based guidelines, which otherwise frequently resulted in a higher-paying secondary diagnosis at discharge. The above eight conditions were identified for non-payment. CMS will no longer reimburse for the additional costs associated with these conditions. In upcoming years, CMS intends to consider additional medical errors and hospital-acquired infections for nonpayment, which will decrease costs and improve care.

On face value, the concept is solid. Why should Medicare pay for misadventure? However, the concept of improving patient outcomes and medical accountability by reducing payments is not without detractors. All outcomes have a multifaceted cause. For example, a catheter-associated infection may have been caused by an infection acquired outside the hospital that only expressed itself after admission. There is also concern that establishing baseline conditions upon hospitalization may increase unnecessary testing procedures (e.g., all admits requiring a blood and urine culture).

These regulations include patient protections to prevent them from being billed if payment is withheld by Medicare. Additionally, a hospital should have the ability to appeal any non-coverage decision (e.g., any infection that may not have been preventable). It will be interesting to monitor both the patient and hospital protections built into the regulations.

The costs associated with medical misadventures and preventable errors are staggering; the intent of the CMS regulation is laudable. It emphasizes the importance of error reporting and the absolute necessity for sound medication reconciliation, infection control, and safe medication practice programs.

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