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NON-PAYMENT FOR MEDICAL ERRORS: *What You Need to Know*

Are pressure ulcers always preventable? How about urinary tract infections (UTI)? If a hospital-acquired infection (HAI) is present, should payment be denied in whole or in part? These are the kinds of questions Medicare has had to field as it developed its new inpatient prospective payment rule, to become effective later this year, to eliminate payment for certain HAIs. For discharges on and after October 1, 2008, hospitals will not receive payment for eight selected conditions:

- Object left in surgery,
- Air embolism,
- Blood incompatibility,
- Catheter-associated urinary tract infections,
- Pressure ulcers (decubitus ulcers),
- Vascular catheter-associated infections,
- Surgical site infections – mediastinitis after coronary artery bypass graft, and
- Hospital-acquired injuries – fractures, dislocations, intracranial injuries, crushing injuries, burns, and other unspecified effects of external causes.

The conditions selected for non-payment (a) are high cost or high volume or both, (b) will result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) are allegedly, reasonably preventable through application of evidence-based guidelines. More conditions will be added in 2009. You should also be aware that Medicare does not pay at all for so-called “never” events such as surgery on the wrong patient or the wrong body part.

The purpose of the new rule is to encourage the application of evidence-based clinical guidelines and to tie pay to performance, efforts shown to save lives and money. Under the old rule, hospitals actually received higher payment for poorer patient outcomes. Medicare will save money under the new system (although, despite the rhetoric, the amount of savings probably will not be large). Non-payment of the higher DRG will apply in only a minority of cases where the selected condition is the only basis for higher payment. If a patient also has one or more non-selected conditions that qualify for higher payment, the higher payment will be made. This concession was important to academic medical centers, which were concerned that the new rule could create a disincentive to treating complicated cases. The usual appeals process is available when there is disagreement regarding a payment adjustment.

Under the new rule it will be more important than ever to identify conditions that are present on admission and to properly code the information. For example, pressure ulcers present on admission will qualify for a higher reimbursement as long as the presence of a stage III or IV ulcer is noted in

the record within two days. Pressure ulcers occurring after that time will not be eligible for additional reimbursement.

Determining whether a UTI was avoidable is particularly difficult, and a good example of the kinds of challenges providers face. Evidence-based guidelines provide that catheters should be used only when necessary, inserted only by personnel familiar with aseptic technique, left in place the minimum amount of time necessary, and maintained with closed, sterile drainage systems. However, prolonged use of catheters cannot always be avoided. Some experts recommend that there should be exceptions for patients who are immunosuppressed, those who require long-term catheter placement for installation of antimicrobial or chemotherapy agents, and those who have sustained urinary tract trauma. In addition, prevention guidelines for avoiding catheter-associated UTIs are due to be updated. Nonetheless, CMS selected the condition for inclusion in the FY 2008 rule. Clearly there will be need for further refinement of the rules, and CMS has indicated its intention to continue to work with the hospital industry during the implementation process.

So what can providers do now to make sure they win the pay-for-performance game?

- Make sure all clinical staff are thoroughly educated regarding evidence-based guidelines for preventing the selected hospital-acquired conditions.
- Step up quality improvement studies of compliance with evidence-based guidelines.
- Make the consistent application of evidence-based guidelines a component in evaluating physician and other practitioner performance and in compensation decisions.
- Train all staff regarding the need to identify and code all “present on admission” conditions.
- Anticipate that Medicaid and commercial payers will follow suit.
- Work through your trade association to recommend revisions to the ICD-9-CM diagnostic codes.
- Non-hospital providers, such as skilled nursing facilities, outpatient clinics, and home health care providers, should anticipate that their industries will be the next target of efforts to tie pay to performance.

If you have a question on this material or would like to discuss legal services, please contact us at healthcare@duanemorris.com.



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