EDUCATIONAL COMMENTARY – IMPACT OF HOSPITAL-ACQUIRED CONDITIONS ON MEDICARE REIMBURSEMENT

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Learning Outcomes
Upon completion of this exercise, participants will be able to:

- describe the way that Medicare currently addresses hospital-acquired conditions.
- delineate 10 categories of hospital-acquired conditions.
- identify the role of diagnostic laboratory services as related to hospital-acquired conditions.

The mechanism by which hospitals have been paid for treating Medicare patients has remained essentially unchanged since the implementation of the inpatient prospective payment system (IPPS), commonly known as the diagnosis-related group (DRG) payments. This system was implemented in 1983 to replace the existing fee for service (FFS) payment system.¹ Under FFS, hospital reimbursement was based on “reasonable cost”; the more services a hospital provided, the greater the reimbursement. There was an inherent risk of overuse in such a payment system, and hospitals were rewarded for excess use of services. For example, the longer a patient stayed in the hospital, the greater the charges and the higher the reimbursement. Before implementation of IPPS, from 1966 to 1982, annual spending growth averaged 19%.

The Prospective Payment (DRG) System
To promote efficiency, the Health Care Financing Administration (HCFA, now the Center for Medicare and Medicaid Services [CMS]) migrated hospitals from an FFS payment system to the IPPS. Under this system, hospitals were paid, with some exceptions, a fixed fee for treating a patient presenting with a given condition and receiving a set of services (e.g., coronary artery disease with bypass surgery). The DRG system was designed to reasonably compensate hospitals for the anticipated cost of providing a service. Some adjustments are made to the reimbursement scheme to account for higher cost in urban areas and to hospitals that have the responsibility to teach future health care professionals.²

Because under the DRG system hospitals are paid prospectively based on diagnosis and procedure, incentives switched to reward hospitals for increasing efficiency. Given a fixed payment, efficient providers that use fewer services for the same patient type end up with a greater profit margin. Of course, this scheme creates, in contrast to fee for service, a potential incentive for underuse of services.
Oversight organizations were created, now known as the Quality Improvement Organizations (QIOs), to monitor patient care to ensure that quality standards are maintained. Following implementation of IPPS, average hospital lengths of stay declined rapidly, from about 10 days in 1982 to just over five days in 2004.

The goal of the Medicare program was to align payment for services with anticipated costs of providing those services. The reimbursement system created a number of DRGs to assure, with some level of confidence, that the costs of caring for patients in any one DRG were fairly homogeneous. That is, the hospitalization of one patient classified to a DRG would be unlikely to be many times more costly than that of another patient described by the same DRG.

**Comorbidities and Complications**
However, research by DRG developers identified that some patients with certain conditions described by a particular DRG algorithm generated statistically higher costs than other patients. Patients with some comorbidities (i.e., patient conditions not directly related to the primary reason for hospitalization that raise patient acuity such as diabetes out of control, severe heart failure, anemia) or complications (e.g., infection, postoperative bleeding) were clearly anticipated to have higher costs. For a subset of DRGs, the reimbursement scheme split DRGs into two groups. Patients with certain conditions (e.g., major chest surgery) would be split into those with a comorbidity or complication (known as a CC) and those without a CC.

**Assigning Hospital Discharges to Specific DRGs**
Rules for assigning DRGs are published annually and DRG assignment is based on a combination of diagnosis and procedure codes that are part of the International Classification of Disease, 9th Revision (ICD-9). Codes are generally assigned by trained and certified hospital coders in health information management departments. Coders are guided by fairly rigid rules that address which codes to use in a particular situation, and how to identify which diagnosis represents the principal diagnosis and which procedure is the principal procedure. Coders are also restricted in the information they can use to make these decisions. For example, coders are prohibited from using any information that may be in a laboratory report unless that information is used and documented in the physician notes by the patient’s physician. While the purpose of this is to prevent coders from using information that may not be clinically significant (e.g., sufficiently significant to warrant a physician comment in his or her note), important information may be lost which could significantly impact coding and reimbursement. For example, if the laboratory report clearly shows that the patient has diabetic ketoacidosis (DKA), but the physician never
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comments on the DKA, the coder cannot code DKA. Diabetic ketoacidosis would be, in many situations, a significant CC that, in the absence of any other CC, could change the DRG assignment from a DRG without a CC to the corresponding DRG with a CC. The with-CC DRGs pay more, sometimes considerably more, than those without CC. It is no surprise, therefore, that hospitals have been working with physicians to make sure that they clearly document patients’ clinical conditions that reside in laboratory, radiology, and other ancillary reports.

2008 Revisions to the DRG Payment System
Recently, Medicare re-examined the IPPS structure and realized that many of the comorbidities and complications, while present, did not with today’s sophisticated medical care, actually consume considerably more resources. For example, a well-controlled diabetic patient without diabetic complications who was undergoing a foot procedure would not be expected to use significantly more resources than a patient who did not have diabetes. Therefore, CMS reformed the DRG system to create what are known as Medicare Severity–Adjusted DRGs or MS-DRGs. With the reform, CMS expanded the number of DRGs and removed many of the ICD-9 codes from the list that would move patients assigned to the lower-paying, without-CC DRG to the higher paying, with-CC DRG.

2009 Adjustment for Acquired Complications
This year, as part of the rules for determining how hospitals would be paid in 2009, CMS responded to concerns that hospitals were being reimbursed higher DRGs for some complications that were actually acquired in the hospital. Consequently, in July 2008, CMS issued its Final Rule that would apply to inpatient Medicare services for the 2009 fiscal year, starting October 1, 2008. Coders were then required to report with each diagnosis whether the condition was present on admission or acquired during the admission. A subset of complications was identified where, when acquired during the hospitalization, the rules would not map that complication to the higher-paying with-CC DRG. For example, if a patient is admitted for cardiothoracic surgery with an existing infection, that patient will be coded to a DRG that acknowledges the infection as pre-existing. However, if that patient develops a surgical wound infection following surgery, the hospital will be paid at the lower DRG, assuming other relevant co-existing comorbidities or complications that could qualify for the higher DRG are not present. The acquired conditions create the situation where the hospital is not paid EXTRA for the acquired condition, but is paid for services at the rate it should have been paid had the patient not acquired what is considered a preventable complication.
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Medicare intends to expand the list of situations that represent preventable conditions for which CMS will not pay extra. The 2009 list, shown in the Table (below), includes a number of conditions where the diagnosis depends, in part, on laboratory medicine services. For example, the data on which to conclude that the patient has an acquired catheter infection or surgical wound infection is in part laboratory based (e.g., findings from culture, elevated WBC count).

TABLE. Hospital-Acquired Conditions Subject to Medicare Payment Implications Effective October 1, 2008.

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility*
4. Stage III and IV pressure ulcers
5. Falls and trauma
   • Fractures
   • Dislocations
   • Intracranial injuries
   • Crushing injuries
   • Burns
   • Electric shock
6. Manifestations of poor glycemic control
   • Diabetic ketoacidosis*
   • Nonketotic hyperosmolar coma*
   • Hypoglycemic coma*
   • Secondary diabetes with ketoacidosis*
   • Secondary diabetes with hyperosmolarity*
7. Catheter-associated urinary tract infection (UTI)*
8. Vascular catheter-associated infection*
9. Surgical site infection following*
   • Coronary artery bypass graft (CABG)—mediastinitis
   • Bariatric surgery
     ▪ Laparoscopic gastric bypass
     ▪ Gastroenterostomy
     ▪ Laparoscopic gastric restrictive surgery
   • Orthopedic procedures
     ▪ Spine
     ▪ Neck
     ▪ Shoulder
     ▪ Elbow
10. Deep vein thrombosis (DVT)/pulmonary embolism (PE)*
    • Total knee replacement
    • Hip replacement

*Situations where laboratory diagnosis may be involved.

Implications for Laboratory Professionals

It is important for hospital laboratories to work with their coders and their physicians to ensure that when complications surface from laboratory reports, those diagnoses are documented by the patient’s physician. Otherwise, in audits of patient medical records, Medicare may discover evidence in a laboratory report (which coders cannot use) of an acquired condition that would have resulted in a payment adjustment. To have not documented and accounted for this situation could be interpreted as an attempt to hide the acquired nature of a condition and potentially lead to allegations of fraud. With appropriately structured systems, laboratory professionals can be instrumental in keeping their hospital systems from encountering such allegations.

There are many opportunities for laboratory professionals to become more engaged in their hospital and ambulatory clinical practices. Understanding and helping to facilitate correct coding is one such situation. This requires venturing outside the confines of the laboratory. However, reaching beyond the laboratory offers new ways for laboratory professionals to demonstrate their value to the health care system while at the same time providing the opportunity to build new professional bridges and relationships.

References


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