mortality measure following CABG surgery beginning with FY 2022.

Once the measures are set, documentation and coding for these measures will begin to be collected and analyzed, although the payment for the measures doesn’t take effect until the implementation year. The result can seem a bit like time travel, with penalties in place today for patients seen in years past.

**Hospital-acquired conditions**

The Hospital-Acquired Condition (HAC) Reduction Program aims to eliminate preventable conditions obtained within the hospital setting. This year, CMS proposed changes including:

1. Establish data submission requirements for newly opened hospitals
2. Establish performance periods for the FY 2018 and FY 2019 HAC Reduction programs
3. Clarify data requirements for Domain 1 scoring (in FY 2016, Domain 1 points were assigned for the Patient Safety Indicator 90 composite index value)
4. Adopt the refined PSI 90 (patient safety for selected indicators) composite measure
5. Change the program scoring methodology from the current decile-based scoring to continuous scoring

**Readmission reductions**

Patients with certain diagnoses frequently return to the hospital after a short period of time. CMS seeks to reduce the high cost associated with such readmissions by targeting those patients. The payment reduction is based on a hospital’s risk-adjusted readmission rate during a three-year period. The conditions currently targeted include:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Total hip arthroplasty/total knee arthroplasty
- Coronary artery bypass graft

Although CMS didn’t propose any significant changes to the readmission reduction efforts in the proposed rule, it did indicate a desire to post excess readmission rates to its Hospital Compare website “as soon as feasible following the hospitals’ preview period.”

For more information on the rule, see CMS’ fact sheet. Comments are due to CMS by June 16, and the agency expects to issue a final rule by August 1. Changes will become effective October 1.

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**HACs and POA: Not just alphabet soup**

*by Michelle M. Wieczorek, RN, RHIT, CPHQ*

In 2010 under the Affordable Care Act, CMS linked Medicare payments to healthcare quality, known as value-based purchasing. However, the push for paying for higher-quality medical care goes back a bit further still.

On November 29, 1999, the Institute of Medicine released a report called *To Err Is Human: Building a Safer Health System*, which indicated that medical errors in American hospitals accounted for as many as 98,000 deaths annually. The report proved to be a clarion call.

And so, under the Hospital-Acquired Conditions/Present on Admission Indicator (HAC/POA) program established by the Deficit Reduction Act of 2005, CMS aimed to eliminate payments for conditions obtained in the hospital setting that could have reasonably been prevented. Under the program, CMS essentially said it would no longer pay hospitals for certain conditions that were not present at the time the patient was admitted to the hospital.

CMS identified 11 categories of conditions, including stage 3 and 4 pressure ulcers, falls and trauma, retained foreign bodies, and surgical site infections (SSI). Since 2009, these HACs will not result in the patient
being assigned to a higher-paying MS-DRG if the POA indicator points to the conditions being acquired after admission.

If that isn’t enough, the hospitals in the lowest-performing quartile for HACs are penalized 1% of their total Medicare MS-DRG payments. In 2016, 75% of the performance in HACs will be in the abstracted measure domain, and CLABSIs (central line–associated bloodstream infection), CAUTIs (catheter-associated UTI), and SSIs will be targeted.

Thus far, the results have been:

- Approximately 1.3 million fewer patients were harmed in U.S. hospitals between 2010 and 2013, which is a 17% decline in HACs
- Approximately 50,000 fewer patients died in the hospital as a result of this reduction in HACs
- Approximately $12 billion in healthcare costs was saved from 2010 to 2013 due to this reduction

The most recent research information from the Agency for Healthcare Research and Quality indicates that while there is progress, HACs are still a significant source of morbidity and cost, and thus there continues to be a focus on them.

An interim update on HACs (see Figure 1 below) indicates that not only are morbidity and associated cost burden affected by a reduction in HACs, but mortalities are as well. Deaths have been averted as a result of a focus on preventing adverse events in the hospital.

### Poor data or poor care?

When it comes to success in the various pay-for-performance initiatives, I often remind clients to first be data skeptics and to understand the root cause of why the data portrays particular outcomes.

Quite simply, it is very important to understand whether there is a problem with the data or a problem with the quality of care. In most cases, it comes down to understanding that clinical documentation and coding for a handful of cases has a significant effect on performance.

HACs are especially relevant to this scenario. For example, a 450-bed acute care hospital was penalized

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**Figure 1:**
**2013 annual HAC rate and estimates of cost savings and deaths averted from 2010 to 2013**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse drug events</td>
<td>43.8%</td>
<td>11,540</td>
<td>$2,885,000,000</td>
</tr>
<tr>
<td>CAUTI</td>
<td>14.4%</td>
<td>4,427</td>
<td>$190,000,000</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.8%</td>
<td>1,998</td>
<td>$183,600,000</td>
</tr>
<tr>
<td>Falls</td>
<td>3.8%</td>
<td>2,750</td>
<td>$361,700,000</td>
</tr>
<tr>
<td>Obstetric adverse events</td>
<td>0.8%</td>
<td>20,272</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>21.2%</td>
<td>1,297</td>
<td>$4,760,000,000</td>
</tr>
<tr>
<td>Surgical site infections</td>
<td>3.5%</td>
<td>1,150</td>
<td>$966,000,000</td>
</tr>
<tr>
<td>Ventilator-associated pneumonias</td>
<td>0.6%</td>
<td>1,150</td>
<td>$168,000,000</td>
</tr>
<tr>
<td>Postop venous thromboembolisms</td>
<td>0.4%</td>
<td>520</td>
<td>$40,000,000</td>
</tr>
<tr>
<td>All other HACs</td>
<td>10.7%</td>
<td>6,387</td>
<td>$2,397,000,000</td>
</tr>
</tbody>
</table>

Source: Agency for Healthcare Research and Quality.
roughly $515,000 in fiscal year 2016 due to four cases of CLABSIs, five CAUTIs, and five SSIs.

So, what can a CDI specialist do? In general terms, one of CDI’s most important roles in an acute care setting is to establish the clinical diagnosis and/or conditions that were POA. A close second is ensuring that patient acuity is clearly represented in the physician documentation so that the true severity of illness and risk of mortality are depicted when codified data is risk adjusted for comparison. Let’s look at a couple examples.

**CLABSI**

The presence of a central line on admission is not always evident to the coder due to the fact that unless a catheter is changed, or obviously infected, it is likely not going to be documented in any detail by the physician in the history and physical.

Therefore, the CDI specialist should review nursing documentation, including ED triage notes, to determine if there is a central line POA. This becomes particularly important if blood cultures have been drawn and on day two or three of the stay they become positive.

The physician must be queried to ascertain if the bloodstream infection was POA and note the clinical indicators that were evident, including the presence of the central line. Failure to clarify the POA status results in the facility being attributed with the CLABSI which has a detrimental effect in pay for performance measures.

Chronic kidney disease, severe protein malnutrition, and diabetes all have a tie to a compromised immune system, making a patient more vulnerable to infection, and thus these diagnoses have an impact on the patient’s predicted risk of mortality and morbidity.

It is as important as ever for the CDI specialist to query the physician for secondary diagnoses that may not have an impact on the MS-DRG assignment but do impact on the depiction of patient acuity. Remember, a handful of patients excluded from a denominator can have a significant effect on financial performance in the HAC Reduction Program.

**Stage 3 and 4 pressure ulcers**

The presence of a pressure ulcer on admission is one of the most frequently occurring physician documentation gaps; as the ulcers do not necessarily drive the acuity of the patient, physicians may overlook documenting their presence altogether, let alone noting their stage and location.

It is often up to the astute CDI specialist to read the skin assessment in nursing or ED triage notes, or refer back to the transfer summary from the skilled nursing facility to look for clues as to the presence of a pressure ulcer.

The role of the CDI specialist in this scenario is two-fold. First, the CDI specialist should obtain acknowledgment of the pressure ulcer and its POA status using the clinical indicators found in the medical record, including any staging information that may appear as part of nursing documentation. Second, while stage 3 and 4 pressure ulcers are still considered MCCs (if the POA status is Y) even if the site is unspecified, the CDI specialist should encourage the provider to document the location of the ulcer in addition to the stage so that the most specific ICD-10 code can be assigned.

**Conclusions**

The role of the CDI specialist is extending into the quality and performance domain through alternative payment methods being implemented by CMS.

As we continue to move away from a pure fee-for-service payment mode, legacy CDI programs built on the foundation of strengthening case-mix index performance through improved capture of CCs and MCCs must change to address a new sphere of clinical documentation issues confronting providers.

CDI specialists must sharpen their focus on capturing any and all diagnoses that may impact patient acuity, and must view clinical documentation through a lens of severity of illness and risk of mortality. In addition, provider attribution issues for adverse events must be clarified well before final coding to ensure that hospitals are not flagged for HACs incorrectly.

**Editor’s note:** Wieczorek is a senior manager at Dixon Hughes Goodman Healthcare. Contact her at michelle.wieczorek@dhgllp.com.