Feds May Stop Pay for Surgical Site Infections

BY BRUCE JANCIN
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PHOENIX — The proposed cessation of Medicare reimbursement for management of surgical site infections would have a deleterious impact on hospital finances and create institutional disincentives for surgery on the sicker, more complex patients at increased risk, Joshua A. Cohn said at a congress sponsored by the Association for Academic Surgery and the Society of University Surgeons.

"This [proposed rule] would likely reduce surgical site infection rates due to significant institutional pressure to improve systems of care, but it would also have unintended consequences. It could affect access to care for sick, high-risk patients as well as leading to systems of care directed not at reducing surgical site infections, as the rule intends, but rather at maintaining revenue," observed Mr. Cohn, a medical student at the University of Michigan, Ann Arbor.

Last August, the Centers for Medicare and Medicaid Services proposed rule CMS-1488-P, which as of Oct. 1, 2008, would end reimbursement for the increased care associated with hospital-acquired infections CMS deems preventable. It is clear from the language of the proposal that CMS considers all surgical site infections (SSIs) as falling within this "preventable" category, he added.

It's well established that SSIs tend to occur in preoperatively sicker patients with multiple comorbidities. Leaving aside the issue of whether in fact most SSIs really are preventable, Mr. Cohn and coworkers sought to find out how much of the cost of the added care associated with SSIs is due to the infection independent of the comorbidities.

For this purpose, they turned to the extensive clinical and financial data gathered as part of the National Surgical Quality Improvement Program on a randomly selected population of 5,409 patients who underwent surgery during 2003-2006 within the University of Michigan Health System.

The 320 patients who developed SSIs had significantly higher preoperative rates of sepsis, chronic obstructive pulmonary disease, and numerous other comorbid conditions, along with increased postoperative complications (see box).

"Patients who were sicker were more likely to get SSIs. And interestingly, most of these factors were obviously beyond the control of the surgical team," Mr. Cohn noted.

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MR. COHN

In a multivariate linear regression analysis controlling for the significant pre- and postoperative factors related to SSIs, the occurrence of an SSI was independently associated with an $8,304 increased cost to insurers. As a result of this payment, the medical center made a profit of $2,738 per patient with an SSI. Had CMS-1488-P been in effect at the time of the study, however, the hospital instead would have lost an average of $5,566 per patient.

The university's infectious disease specialists place the institutional SSI rate at about 3%. Because 61,000 operations per year are performed within the University of Michigan Health System, that adds up to 1,830 SSIs. If other insurers were to follow the CMS lead, the result would be a $15,200,000 per year loss in revenue.

He predicted that among the consequences of rule 1488-P might be an incentive for hospitals to open new laparoscopic surgery centers, because fewer SSIs occur with laparoscopic procedures.

Audience members expressed dismay that payers would classify SSIs as preventable. They also predicted that, if implemented, 1488-P would fail because it attempts to change physician behavior without affecting physicians' fees. ■

Patients Who Develop Surgical Site Infections Are Sicker Beforehand

	% of Patients	
Preoperative Status	**With SSI**	**Without SSI**
Dyspnea	17.4	9.7
Open wound	14.6	4.0
Bleeding	9.0	4.2
Sepsis	7.9	4.3
COPD	7.9	3.7
Postoperative Complications		
Systemic inflammatory response syndrome	15.9	2.3
Acute renal failure	2.8	0.5
Deep venous thrombosis	2.2	0.5

Note: Based on a study of 5,409 patients; COPD is chronic obstructive pulmonary disease.
Source: Mr. Cohn

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POLICY & PRACTICE

Surge in Nonsurgical Procedures

The latest data from the American Society for Aesthetic Plastic Surgery (ASAPS) show that the number of nonsurgical cosmetic procedures increased 747% in the last decade, far outstripping the 98% growth in surgical cosmetic procedures. In 2006, there was a 4% increase in nonsurgical procedures over 2005, with botulinum toxin type A (Botox) injections topping the list (3.1 million procedures), followed by hyaluronic acid fillers (1.5 million), laser hair removal (1.4 million), microdermabrasion (993,000), and laser skin resurfacing (576,000). Most patients were aged 35-50 years. Average physician fees range from about $400 for collagen and Botox injections to $1,000 for poly-L-lactic acid (Sculptra) injections. ASAPS found that 17% of members it surveyed work with "legitimate" medical spas where nonsurgical procedures are offered. The society also noted that consumer backing of cosmetic surgery is at an all-time high. According to its survey (released in February) of 1,000 households, 63% of women and 61% of men said they approve of cosmetic surgery. A third of women and 18% of men said they'd consider cosmetic procedures for themselves in the future. The survey was sponsored by ASAPS and conducted by Synovate, an independent research firm.

Hill Wants Tanning Bed Study

Rep. Carolyn Maloney (D-N.Y.) and her colleagues in the House and Senate have introduced bills that would require the Food and Drug Administration to study whether current tanning bed warnings give consumers enough risk information. The legislation, HR 945, also would have the agency explore whether warnings suggested by the American Academy of Dermatology or other groups might be better, and test those warnings on consumers. A report would be due 1 year after enactment of the law. The Senate companion bill was introduced by Jack Reed (D-R.I.).

Coal Tar/Menthol OK for Dandruff

The FDA has ruled that a combination of 1.8% coal tar and 1.5% menthol is generally recognized as safe and effective when combined in dandruff and anti-itch shampoos. The agency proposed in December 2005 to accept those ingredients in combination for over-the-counter shampoos used to treat dandruff, seborrheic dermatitis, and psoriasis. It did not receive any comments on the proposal and issued the final rule on March 5, 2007. According to the FDA, manufacturers have the option to reformulate current shampoos that have coal tar to include menthol or to produce a new shampoo containing both ingredients.

Ex-FDA Chief Avoids Jail

Former FDA Commissioner Lester Crawford, D.V.M., Ph.D., will pay a $90,000 fine and perform 50 hours of community service under a sentence handed down by a U.S. District Court magistrate judge in late February. Dr. Crawford abruptly resigned his post in September 2005, with no explanation. He did not admit to any wrongdoing until October 2006, when he pleaded guilty to conflict of interest and false financial reporting. Prosecutors had determined that Dr. Crawford and his wife inappropriately held stocks in companies the FDA regulated—together earning $39,000 from options and dividends—and later paid taxes on those gains. Dr. Crawford had worked out a deal to pay $50,000 in exchange for no jail time. But Magistrate Judge Deborah A. Robinson found that prosecutors violated sentencing guidelines and she imposed the stiffer fine.

Majority Want Access Guarantee

Nearly two-thirds of Americans believe the federal government should guarantee access to health care, and 60% are willing to pay more in taxes for that guarantee, according to a poll released last month by The New York Times and CBS News. Half of those polled said they would be willing to pay as much as $500 a year in additional taxes, while nearly 8 in 10 said they thought it was more important to provide universal access to health insurance than to extend the Bush administration's tax cuts. In addition, a quarter of those with insurance said that they or someone in their household had gone without a medical test or treatment because insurance would not cover it; 60% of those without insurance reported the same situation. The nationwide telephone poll of 1,281 adults was conducted in late February 2007.

Health Spending Continues to Soar

Health care spending in the United States will continue to grow over the next decade, nearly doubling to $4.1 trillion by 2016, according to an analysis by the Centers for Medicare and Medicaid Services. The analysts project that the average annual growth in health care spending will remain at around 6.9% for the next 10 years. The findings were published in the Feb. 21 Web edition of Health Affairs. Prescription drug spending will continue to rise, they predict. By 2016, prescription drug spending is expected to reach $497.5 billion, more than double the spending for 2006. The rate of growth in physician and clinical spending is expected to slow down in the coming decade, according to the analysis. However, even with the deceleration, spending for physician services is expected to reach $819.9 billion by 2016. Physician spending in 2006 is projected at $447 billion. "As the nation moves from more traditional sources of insurance, such as employer-based coverage, to more federal- and state-provided health care, we will continue to face tough questions about how we finance our health care bill," John Poisal, deputy director of the National Health Statistics Group at CMS, said in a statement.

—Alicia Ault