Implications of the New Centers for Medicare & Medicaid Services Pressure Ulcer Policy in Acute Care

Cynthia A. Fleck, RN, BSN, MBA, ET/WOCN, CWS, DNC, CFCN, FACCWS^{a,*}

^aMedline Industries, Inc., Advanced Skin and Wound Care Division, Mundelein, IL, USA

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Abstract One of the leading questions on clinicians' minds is, What are the implications of the new ruling of the Centers for Medicare & Medicaid Services (CMS) in acute care, and how will it affect the wound care clinician? The CMS recently unveiled its plans for reimbursement and nonpayment for facility-acquired pressure ulcers, among other issues, in acute care. Change is coming, and this time prevention and intervention underlie the CMS payment reform ruling, which includes payment incentive for prevention and quality patient care. Intensive and comprehensive patient screenings at the outset of admission, as well as diligent prevention during patient stay, are the mainstays of this initiative. Anyone who works in a hospital will play a major role.

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Introduction

One of the leading questions on clinicians' minds is, What are the implications of the new ruling of the Centers for Medicare & Medicaid Services (CMS) in acute care, and how will it affect the wound care practitioner? The CMS recently unveiled its plans for reimbursement and nonpayment for facility-acquired pressure ulcers, among other issues, in acute care. Change is coming, and this time prevention and intervention underlie the CMS payment reform ruling, which includes payment incentive for prevention and quality patient care. Intensive and comprehensive patient screenings at the onset of admission, as well as diligent prevention during patient stay, are the mainstays of this initiative. Anyone who works in a hospital will play a major role.

The CMS fact sheet on Hospital-Acquired Conditions (HAC) in acute Inpatient Prospective Payment System (IPPS) hospitals outlines these changes and is available at http://www.cms.hhs.gov/HospitalAcqCond/Downloads/hac_fact_sheet.pdf.

Background

Health care spending is on the rise, with dramatic increases in just the past 5 years. Where are the dollars being spent? An estimated \$570.8 billion is going to pay for care provided in hospitals alone.¹ The government was on the prowl for burden that included either high-cost or high-volume or both health care issues. For example, in fiscal year (FY) 2006, there were 322,946 reported cases of Medicare patients who had a pressure ulcer as a secondary diagnosis.² Additional average charges for the hospital stay (per case) were \$40,381.² An estimated 2.5 million patients are treated each year in US acute care facilities for pressure ulcers.³ This nets out to a staggering \$1.3 billion. In addition, 60,000 patients die each year from pressure ulcer complications.⁴

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* Corresponding author.

E-mail address: cynthiafleck@sbcglobal.net

Changes began with the Deficit Reduction and Reconciliation Act (<http://www.cms.hhs.gov/HospitalAcqCond/Downloads/DeficitReductionAct2005.pdf>) of 2005, Hospital-Acquired Conditions (HACs), which required that by October 1, 2007, CMS must identify at least 2 conditions that meet the following criteria:

- Are high cost or high volume or both.
- Result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines.

CMS released its final rule on hospital payments or reimbursement under the IPPS for FY 2008 on August 1, 2007. Decisions made in this rule were based on laws passed years ago, including nonpayment for “never events” and eliminating payment for marginal or poor care in acute care. CMS announced 8 HACs that are deemed preventable (meaning there is evidence-based information supporting the fact that these conditions could be prevented with proper care). Two more conditions were added on October 1, 2008 and the condition of surgical site infection was modified (see final list under the section titled “Changes”). The CMS IPPS Final Rule for FY 2008, a 2,140-page document, is available for download in pdf format at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>. The section that addresses pressure ulcers can be found on pages 311-317. Monitoring the statutory implementation of the HACs and the present on admission (POA) indicators at regular intervals is recommended. Updates are available at http://www.cms.hhs.gov/HospitalAcqCond/01_Overview.asp#TopOfPage.

How Will These Changes Affect the Budget?

The entire system is really budget neutral, which means that the base rate for all DRGs has been reduced to allow for some higher payments for more severe patient conditions. The purpose is to enhance matching of the payment to the severity of the patient. Included in the rule are provisions providing less payment for certain HACs.

Changes

The following changes (with their page numbers in parentheses) are included in the Final Rule:

- Surgical site infections (pp. 345-348).
- Surgical site infection following coronary artery bypass, gastroenterostomy, laparoscopic gastric restrictive surgery, and orthopedic procedures such as those on the spine, neck, shoulder, or elbow (examples: total knee and bariatric surgeries).

- Catheter-associated urinary tract infections (pp. 303-311).
- Objects left in the body postsurgery (gossypiboma; pp. 317-321).
- Stage III and IV pressure ulcers (pp. 311-317).
- Vascular catheter-associated infections (pp. 323-330).
- Hospital-acquired injuries (pp. 352-357).
- Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock).
- Air embolism (pp. 319-321).
- Blood incompatibility (pp. 321-323).

After public comment, the following new HACs were added, effective October 1, 2008⁵:

- Certain manifestations of poor blood sugar levels, primarily diabetic hyperosmolarity, ketoacidosis, and hypoglycemic coma.
- Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures.

As of October 2008, Medicare will no longer pay for these preventable conditions if they are acquired during the hospital stay. Hospitals should be aligning policies, procedures, and personnel as well as choosing best-in-class products to prevent these nosocomial events and offer quality patient care. This can be accomplished by ramping up educational programs to prepare their facilities for change and by developing relationships with vendors to provide cost-effective products and programs to streamline care and save money.

Several new terms to know and understand with regard to the changes, some introduced earlier, are summarized here:

- Medicare severity-diagnostic related group (MS-DRG).
- Present on admission (POA).
- Hospital-acquired condition (HAC).
- Inpatient Prospective Payment System (IPPS).

POA Indicator

For discharges on or after October 1, 2007, hospitals must use ICD-9 diagnosis codes and POA indicators to report whether pressure ulcers were detected on hospital admission. The condition must be present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. Data are now being captured from October 2007 through October 2008. The payment penalty will go into effect in FY 2009 (beginning October 2008). Hospitals were required to begin capturing data on HACs in FY 2008 (which began October 2007).

If the patient is discharged with a facility-acquired pressure ulcer but is later readmitted with a different diagnosis, the pressure ulcer will then be considered POA and may be eligible for a higher MS-DRG payment.

Key dates and designated actions are as follows:

- **October 1, 2007:** Hospitals are mandated to begin capturing and submitting data on HACs in FY 2008 on discharges.
 - Health care providers must work out the “bugs” in their facility’s documentation system.
 - Admissions records must indicate a POA indicator for both primary and secondary diagnoses.
- **January 1, 2008:** Review of claims began.
- **April 1, 2008:** Claims were be returned for correction if not reported accurately.
- **October 2008:** The payment penalty will not go into effect until FY 2009.
 - Hospitals will receive comment if conditions are not accurately reported.
 - Codes not on report and conditions not listed on the aforementioned rule will be considered nosocomial (hospital acquired) and no longer will qualify for increased DRG and payment.

Table 1 illustrates the 5 POA reporting options. As it stands today, reporting must rely solely on physicians’ notes and diagnoses and cannot make use of notes from nurses and other practitioners.

Who Is Exempt?

Some facilities are exempt from POA indicators and HACs. The new rulings do not apply to the following types of facilities: critical access hospitals, long-term care hospitals, Maryland waiver hospitals, cancer hospitals, and children’s inpatient facilities. The exempt facilities are sole community hospitals, rural referral centers, medicare dependent hospitals, rural health clinics, federally qualified health centers, religious non-medical health care institutions, inpatient psychiatric hospitals, inpatient rehabilitation facilities.

Specifics

Stage I and stage II pressure ulcers POA will *not* qualify for the higher Medical Severity Diagnostic Related Group (MS-DRG) payment. Stage III or stage IV pressure ulcers POA *will* qualify for the higher MS-DRG payment (except elbow ulcers or those in “unspecified” locations). Coding changes have been proposed to replace the current method,

which is based on location. The new coding will be based on staging or severity. The physician or provider will be required to identify and document this information. CMS recognizes that often patients who get pressure ulcers are very ill and frequently have comorbidities and difficult conditions that will qualify the patient for the higher-paying MS-DRG. This fact should not preclude physicians and hospitals from screening *all* patients for pressure ulcers on admission, including those who enter through the emergency department or operating department for any surgery.

Pressure Ulcer Stage Codes Effective October 1, 2008

Pressure Ulcer Stages

Two codes are needed to completely describe a pressure ulcer: a code from subcategory 707.0, *pressure ulcer*, to identify the site of the pressure ulcer, and a code from subcategory 707.2, *pressure ulcer stages*. The codes in subcategory 707.2 are to be used as an additional diagnosis to a code or codes from subcategory 707.0. Codes from 707.2 may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should be used only with pressure ulcers and not with other types of ulcers (eg, stasis ulcers). The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) classifies pressure ulcer stages on the basis of severity as stages I-IV and unstageable.

Unstageable Pressure Ulcers

Assignment of code 707.25, *Pressure ulcer, unstageable*, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (eg, the ulcer is covered by eschar or has been treated with a skin or muscle graft) and for pressure ulcers that are documented as deep tissue injury but not documented as caused by trauma. This code should not be confused with code 707.20, *Pressure ulcer, stage unspecified*. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

Documented Pressure Ulcer Stage

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation with the terms found in the index. If clinical terms are used that are not found in the index or if there is no documentation of the stage, the provider should be queried.

Bilateral Pressure Ulcers With Same Stage

When a patient has bilateral pressure ulcers (eg, both buttocks) and both pressure ulcers are documented as being

Table 1 The 5 POA Reporting Options*

YES	Present at the time of inpatient admission.
NO	Not present at the time of inpatient admission.
U	Documentation is insufficient to determine if the condition is present at time of admission.
W	Provider is unable clinically to determine whether the condition was POA or not.
BLANK	Exempt from POA.

*Reporting must rely solely on physicians’ notes and diagnoses and cannot make use of notes of nurses or other practitioners.

the same stage, only the code for the site and one code for the stage should be reported.

Bilateral Pressure Ulcers With Different Stages

When a patient has bilateral pressure ulcers at the same site (eg, both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.

Multiple Pressure Ulcers of Different Sites and Stages

When a patient has multiple pressure ulcers at different sites (eg, buttock, heel, shoulder) and each pressure ulcer is documented as being at a different stage (eg, stage III and stage IV), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

Patients Admitted With Pressure Ulcers Documented as Healed

No code is assigned if the documentation states that the pressure ulcer is completely healed.

Patients Admitted With Pressure Ulcers Documented as Healing

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, *Pressure ulcer stage, unspecified*.

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or is being treated for a healing pressure ulcer, query the provider.⁹

Patient Admitted With Pressure Ulcer Evolving Into Another Stage During the Admission

If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.⁶ The key word to use is

"evolving". In other words, the ulcer is evolving to the higher stage.

Bottom Line

The 10 targeted conditions (if acquired during the hospital stay) would be reassigned to lower-paying MS-DRGs. In the past, they would be recoded to a higher-paying DRG. This proposal is expected to save the federal government 4.8% of the current payments to hospitals over a 3-year period. If a hospital does not submit its outcomes data, it will receive a 2% reduction of its payments.¹ In the past, if something went wrong and the patient got sicker, the hospital need not have worried because the "upcoding" in the DRG billing would pay for the additional costs. A much different scenario emerged after October 1, 2008. See [Figure 1](#).

Safety and Finances

In essence, this new rule is a safety and finance arrangement between the hospital and the federal government. If the hospital has a patient who acquires a preventable condition, then rather than pay for the problem, Medicare will pay only for the codes that were POA. Hospitals will need to assess patients very critically. Physicians' progress notes are key to reimbursement. They must reflect and record issues on admission. At a recent hearing, however, coding experts acknowledged the need to review pressure documentation by varying professional health care disciplines. Currently there is a push to include nurses and other practitioners in a specific pressure ulcer section of the chart. Originally, the position was to review only the physician's note. These as well as other details will be resolved as time progresses.

The Basics

Preparation for these changes should begin immediately and may morph as the Final Rule is interpreted by facilities. Commence by assessing your exposure and evaluating 2006 data against the new payment rules for 2009. Establish

A much different scenario emerges after October 1, 2008:

- Mr. M.B. enters the hospital for pneumonia. His skin is in good condition, without breakdown. He develops a stage III pressure ulcer on his coccyx on day 3 of his hospitalization. Under the final rule after October 2008, the hospital will not receive an increase payment or reimbursement, and must care for Mr. M.B.'s ulcer without more funds from CMS.

Figure 1 Case Example.

quality improvement task forces. Meet with consultants and business partners to identify and find new ways to improve. Finally, develop preventive strategies to reduce HACs and accurately assess the patient on admission. The consensus paper titled “New Opportunities to Improve Pressure Ulcer Prevention and Treatment Implications of the CMS Inpatient Hospital Care Present on Admission (POA) Indicators/Hospital-Acquired Conditions (HAC) Policy,” by the International Expert Wound Care Advisory Panel, is now obtainable and contains highlights of a roundtable discussion by a transdisciplinary group of industry leaders. It is available at <http://www.medline.com/opportunitiestoimprovepressureulcerpreventionandtreatment.pdf> and provides key prevention ideas, strategies, education, and training for success.

What are some basic things that staffs need in order to move in the right direction? Start with education and implementation of the following prevention guidelines:

- National Pressure Ulcer Advisory Panel Pressure Ulcer Prevention Guidelines, available at http://www.npuap.org/PU_Prev_Points.pdf.new
- Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3 AHCPR Pub. No. 92-0047, May 1992, available at http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=h_stat2.chapter.4409. Keep in mind that this document is old and many of its citations antiquated, and it may no longer be current.
- Wound, Ostomy and Continence Nurses Society Guideline for Prevention and Management of Pressure Ulcers (WOCN Practice Guideline Series No. 2), available at: http://www.wocncenter.com/members/bookstore/store_details.cfm?pk_products=29.

Next, a thorough assessment must be performed on admission and at daily intervals for every patient, including risk assessment utilizing a clinically validated risk assessment tool such as the Braden Scale. Prevention, training, and monitoring the documentation practices of key personnel, including nurses and physicians, are important tasks. Finally, the right products, programs, and protocols to decrease these 10 conditions must be put into practice.

Some simple strategies are appropriate:

- Conducting a pressure ulcer admission assessment for all patients.⁷
- Reassessing risk for all patients daily.⁷
- Systematically inspecting skin daily.⁷
- Managing moisture.⁷
- Providing quality skin care.⁸
- Optimizing nutrition and hydration.⁷
- Minimizing pressure.⁷

The New Jersey Hospital Association Collaborative to Reduce the Incidence of Pressure Ulcers reports a 70% reduction in the incidence of pressure ulcers in 2 years, from 18%, down to 5%, using similar programs. Its focus was on prevention, 2-day sharing-and-learning sessions, and observing and performing best practice wound prevention and management.¹⁰

Other possible solutions include the following:

- Two or more clinicians’ performing visual exams or rapid access teams’ being deployed to the emergency department or other point of entry, when patients are admitted.
- Since pressure ulcers can occur within 2 hours or less, providing an expanded view around high-risk situations

Figure 2 Example of Bedside High Frequency Ultrasound Image. Pictures courtesy of Longport, Inc. Glen Mills, PA, makers of the EPISCAN.

Figure 3 Example of a Wound Accurately Measured With Digital Planimetry. Photo courtesy of Dr. Martin Wendelken.

that could lead to pressure ulcers such as the Emergency Department, operating room and peri-operative department, dialysis and diagnostic areas as well as all surfaces that contact the patient's skin and soft tissue, is recommended.

- Providing support surfaces that redistribute pressure on every examination and operating room table, stretcher, pre-operative and post-anesthesia unit, and bed and chair in a facility.
- Using bedside high-frequency ultrasound that allows visualization of tissue beneath the wound, undermining, sinus tracts, edema, and foreign bodies, permitting clinicians to notice problems early, document effectiveness of wound treatments (Figure 2), and photograph skin area to document conditions.
- Instituting more rigorous efforts to ensure high-risk patients are repositioned every 2 hours or more often.¹¹
- Pushing for more comprehensive documentation, with emphasis on the physician or providers. CMS defines *provider* as "a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis" (www.cms.hhs.gov/HospitalAcqCond/Downloads/poa_fact_sheet.pdf).
- Educating physicians, other providers, and coders within the institution.

Overall Concepts and Summary

Prevention of pressure ulcers and other avoidable conditions is the responsibility of the accepting provider and included in episode cost. Products such as high-quality advanced skin care products that nourish the skin at the cellular level with amino acids, vitamins, and minerals; soap and surfactant-free cleansers^{8,12}; pressure-redistribution mattresses and cushions; nutritional supplements and early intervention by a registered dietitian; superabsorbent

polymer (able to remain continuously dry against a patient's skin while absorbing multiple voids) under pads for incontinence; and educational wound management dressing packaging that offers a quick lesson in wound care and directions for use on every wrapper: All these will assist facilities in the prevention of all pressure ulcers.

New tools such as digital planimetry photo documentation can dramatically improve efforts at measuring and documenting progress in wounds in the field by reducing the margin of error with hand measurement, which is about 30%, down to less than 4%.¹³ Figure 3 shows an example of a wound measured with digital planimetry.

What Does 2009 Hold?

An eventual goal of CMS is to use the pressure ulcer codes as a quality reporting measure and to have the pressure ulcer data published on the hospital report card. In addition, the Centers for Disease Control is considering a new code group for pressure ulcers. A hearing was held on this issue in September 2007 (agenda available at <http://www.cdc.gov/nchs/data/icd9/agendaSep07.pdf>). Cost containment, prevention of avoidable conditions, and quality of care will remain paramount. CMS will most likely target new conditions in the future. The following conditions are being considered:

- Ventilator-associated pneumonia.
- *Staphylococcus aureus* septicemia.
- *Clostridium difficile*-associated disease.
- Legionnaire's disease.
- Iatrogenic pneumothorax.
- Delirium.

References

1. Centers for Medicare and Medicaid Services (CMS). Hospital Acquired Condition/Present on Admission Indicator, available at: <http://www.cms.hhs.gov/hospitalAcqCond>. Accessed April 11, 2009.
2. Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS changes to the hospital inpatient PPS and FY 2008 rates. Final rule. Available at: <http://www.cms.hhs.gov/InpatientPPS/downloads/CMS-1533-FC.pdf>. Accessed September 16, 2008. Page 311.
3. Lyder CH: Pressure ulcer prevention and management. JAMA. 2003; 389:223–226.
4. Reddy M, Gill SS, Rochon PA: Preventing pressure ulcers: a systematic review. JAMA. 2006;296:974–984.
5. Centers for Medicare & Medicaid Services. Medicare and Medicaid move aggressively to encourage greater patient safety in hospitals and reduce never events. Available at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3219&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>. Accessed September 16, 2008.
6. ICD-9-CM official guidelines for coding and reporting; effective October 1, 2008; Chapter 12: Diseases skin and subcutaneous

- tissue (680–709), pages 51–52. Available at: www.cdc.gov/nchs/data/wh/ftp/serv/ftp/cd9/icdguide08.pdf. Accessed September 16, 2008.
7. Ayello EA, Lyder CH: A new era of pressure ulcer accountability in acute care. *Adv Skin Wound Care*. 2008;21:134–140.
 8. Fleck CA, McCord D: The dawn of advanced skin care. *Extended Care Product News*. 2004;95(5):32, 34–39.
 9. Holmes A, Edelstein T: Envisioning a world without pressure ulcers. *ECPN*. 2007;(8):24–29.
 10. Centers for Medicare & Medicaid Services. State operators provider certification (pub. 100-07; p. 9). Available at <http://www.mehca.org/Members%20Only/S&C-08-28.02.TransmittalPageAppPP.F371-F325.pdf>. Accessed February 17, 2009.
 11. Kosiak M: Etiology of decubitus ulcers. *Arch Phys Med Rehabil*. 1961;42(1):19–28.
 12. Fleck CA: Managing ichthyosis: a case study. *Ostomy/Wound Manage*. 2006;52(4):82–93.
 13. Wendelken ME, Alvarez OM, Comfort C, et al. Digital planimetry software provides accurate wound measurements that assist in the prediction of wound closure. Poster and oral presentation at the American Professional Wound Care Association annual conference, Philadelphia, PA, April 2007.