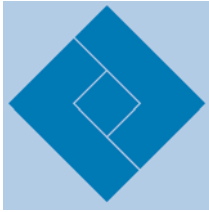




**GUEST COMMENTARY: CMS**



# *Medicare Changes to the Hospital Inpatient Prospective Payment Systems*

## *Commentary on the Implications for the Hospital-Based Wound Care Clinician*

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The United States Centers for Medicare and Medicaid Services (CMS) have revised the inpatient prospective payment system in order to better recognize and reimburse facilities that care for the sickest patients. Efforts to refine the current diagnosis-related groups (DRG) has led to the adoption of a Medical Severity DRG classification system, also called the MS-DRG. The change from DRG to the MS-DRG is to be budget neutral, in that payments will be reduced for some conditions to allow for higher payments for more severe conditions. For each MS-DRG, there will be 3 levels of payment: basic, intermediate, and high. Effective October 1, 2007, hospitals started using the new MS-DRG for tracking and data collection. Beginning October 1, 2008, the new payment rates will go into effect, matching the higher payments with the sickest patients.<sup>1</sup>

One of the provisions in the final rule is the identification of high cost; high volume conditions that can reasonably be prevented using the application of evidenced-based guidelines.<sup>1</sup> Pressure ulcers have been identified as 1 of 8 different conditions that meet this criterion. Using the proposed codes, a Stage I or Stage II pressure ulcer present on admission will not qualify for the higher MS-DRG payment. A Stage III or Stage IV pressure ulcer present on admission will qualify for the high MS-DRG payment (except if it is on the elbow or an unspecified location, which will receive the intermediate MS-DRG payment.) Pressure ulcers will be considered present on admission if they are documented by the end of the second day. An example is a patient admitted at 2:00 PM on Monday. The pressure ulcer must be documented by 11:59 PM on Tuesday. If the pressure ulcer is hospital-acquired, this will not qualify for the higher MS-DRG payment. Patients who are readmitted with the same diagnosis and with a hospital-acquired pressure ulcer from their original admission will not qualify for the high MS-DRG payment. Patients readmitted with a new diagnosis and with a hospital-acquired pressure ulcer from their original admission will qualify for the high MS-DRG payment.<sup>2</sup>

On September 28, 2007, we were invited to represent the WOCN Society at a joint CMS/CDC International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) Coordination and Maintenance Meeting. In preparing to give testimony at this meeting, we worked closely with CMS and the National Pressure Ulcer Advisory Panel (NPUAP) in order to draft concerns and comments. We were in support of an expansion to the current ICD-9 pressure ulcer codes in order to more effectively track wound severity. The current ICD-9 codes only track wound location. The Society supported the expansion of pressure ulcer codes to include the Stages I to IV as well as unstageable and suspected deep tissue injury (DTI). While no decisions were formalized at this meeting, we did gain insight into the process, which we believe will be helpful for clinicians as we implement this rule.

CMS is clearly using their experience with pressure ulcer tracking and public reporting in long-term care (LTC) as the model for hospitals. They acknowledge that the overall number of pressure ulcers in LTC has stayed constant, in spite of efforts to reduce incidence through more aggressive prevention programs. We believe this outcome suggests that some pressure ulcers are unavoidable. Nevertheless, the number of Stage III and Stage IV pressure ulcers has been reduced (but not eliminated) with their efforts at collecting and tracking data. LTC data are reported publicly on the Nursing Home Compare Web site (<http://www.medicare.gov.NHCompare>.) CMS plans to track hospital-acquired pressure ulcers and to eventually report these data publicly on a hospital report card. They are hopeful that this

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public reporting will give hospitals an incentive to improve performance.<sup>2</sup>

CMS further acknowledged that Stage I pressure ulcers can be difficult to detect, and therefore, plan to treat them as a "preulcer" and an indicator of risk. They view Stage II ulcers as minimal injuries that usually heal rapidly and uneventfully. CMS is clearly focusing on the reduction of Stage III and Stage IV hospital-acquired pressure ulcers.<sup>2</sup> CMS is recommending to the CDC that pressure ulcer staging be added as an expansion to the current ICD-9 codes so that pressure ulcer severity can be tracked. At this point, we are uncertain whether this expansion will include provisions for unstageable pressure ulcers or suspected DTI. WOCN and the NPUAP both support the addition of 2 separate ICD-9 codes for unstageable and suspected DTI. There is also still a question as to whether payment will be tied to these additional codes if they are present on admission.

Last, but not least, the regulation clearly requires coders to use physician documentation as the basis for coding and reporting.<sup>1</sup> CMS representatives stated that they have heard comments from the wound care community, as well as from coders, that accurate identification and staging of pressure ulcers requires advanced education and assessment skills, and that this level of documentation is usually found in the nursing record. Recommendations have been made to alter the documentation requirements of pressure ulcers present on admission to include the identification and assessment of nursing professionals. We are uncertain if this requirement will be changed. We suggest that wound care clinicians continue to educate nursing staff and physicians on the importance of early skin inspection and the prompt identification and documentation of all alterations of the skin present on admission. Later assessment and staging of the ulcer may likely be acceptable if there is an indication that the wound was definitely present on admission.

CMS reports in the *Federal Register* that in fiscal year 2006, there were 322,946 reported cases of Medicare patients where a pressure ulcer was reported as a secondary diagnosis. These cases had average reported charges for the hospital stay of over \$40,000.<sup>1</sup> Consideration of these data raises multiple relevant questions: (1) How many of these pressure ulcers were partial thickness versus full thickness? (2) How many of these pressure ulcers were infected? (3) How many of these pressure ulcers required debridement or surgical intervention? (4) How many of these pressure ulcers were hospital acquired? (5) What was the average length of stay? (6) What were the patients' pressure ulcer risks and comorbidities? (7) How many of these were unavoidable? Certainly, no one knows the answers to any of these questions. CMS believes this new rule will improve the screening of patients entering hospitals, and pressure ulcers will be discovered earlier and treatment will ultimately be improved for this preventable condition.

As we consider the unavoidable pressure ulcer, the burden of proof still lies with the facility. We think it is legitimate to question whether pressure ulcers are truly unavoidable in the sickest and most debilitated patients. Comments to CMS have expressed concern that the sickest patients are the ones most likely to develop complications, including pressure ulcers and infections.<sup>1</sup> It is interesting to note that while substantial improvements in bed and chair support surfaces, incontinence cleansers, skin protectants, briefs, and underpads have occurred, a significant reduction on the national pressure ulcer rate has not occurred. Practices and processes have been improved; quality improvement initiatives aimed at pressure ulcer prevention have increased, and there has been increasing regulatory and legal focus on pressure ulcers. In spite of these factors, the national pressure ulcer rate has remained stable.<sup>3</sup> Does this finding suggest that the skin is an organ that can sometimes fail in spite of having access to the very best products and using our very best preventive efforts? The articles in this issue of the journal offer some interesting viewpoints on this question.

Many clinicians will question whether this regulatory focus on hospital-acquired pressure ulcers will change processes and practices. We suspect that it will. Can hospitals do a better job? We think that they can. Will this effort by CMS lead to a reduction in Stage III and Stage IV hospital-acquired pressure ulcers? Time will tell. But we feel that any effort to improve prevention, assessment, and documentation as it relates to the early identification of pressure ulcers will ultimately serve to strengthen the facility's burden of proof in the cases where the pressure ulcer was unavoidable.

As we write this commentary, there continue to be many questions and concerns from the wound care community as this evolves and payment ramifications are realized. We see this rule change as a positive step for our patients and our profession. It validates the work and acknowledges the efforts that we take every day as the skin champions in our facilities. We believe it certainly will elevate the status of the WOC nurse as a change agent in his/her respective facility.

## References

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