

Inpatient Prospective Payment Changes: A Guide for the WOC Nurse

Introduction

On October 1, 2007, The Centers for Medicare and Medicaid Services (CMS) announced a transformational change in how hospitals will be paid. This change involves the implementation of a new payment system that will reward hospitals for quality care and avoids payment for unnecessary and preventable costs.

Many questions and uncertainties have been posed regarding the impact this change will have on hospitals. The intent of this guidance document is to assist members in interpreting the rule in relation to pressure ulcers.

MS-DRGS

The new payment system is known as the Medical Severity-Diagnosis Related Groups, or MS-DRGs. The old payment system was based on a total of 358 DRGs. The new system reorganized this structure, reducing the number of DRGs down to 335. Each group is now subdivided into different levels of medical severity, resulting in a total of 745 MS-DRGs. It is hoped this effort will better capture the presence of complications and comorbidities present on admission and occurring throughout the hospitalization. The intent of this change is to more fairly pay hospitals for the level of care they provide. The hospital will receive less reimbursement for uncomplicated cases and will receive higher payment for the cases involving major complications and comorbidities.

Incentives for Quality Care

As a part of transitioning to this new form of payment, CMS has incorporated incentives for quality care. They have noted that hospital-acquired conditions are a leading cause of mortality and morbidity in the United States, estimating costs at \$17 to \$29 billion. They have identified certain conditions that are found to be high volume/high cost and can be reasonably prevented with evidenced based guidelines. On October 1, 2008, all hospitals currently reimbursed by prospective payment will no longer receive additional payment for certain hospital-acquired conditions. Eight conditions have been initially identified in the new rule to include:

- Object left in surgery
- Air embolism
- Blood incompatibility
- Falls
- Mediastinitis
- Catheter associated urinary tract infection
- Pressure ulcers
- Vascular catheter associated infection

Additional conditions are being considered for future inclusion on this list.

Pressure Ulcers

Pressure ulcers are a quality of care issue impacting many WOC nurses. In July 2008, CMS and CDC released a rule clarification on the codes for pressure ulcers.

The current pressure ulcer codes are defined by location:

- 707.00 – Pressure ulcer, unspecified site
- 707.01 – Pressure ulcer, elbow
- 707.02 – Pressure ulcer, upper back, shoulder blade
- 707.03 – Pressure ulcer, lower back, sacrum
- 707.04 – Pressure ulcer, hip
- 707.05 – Pressure ulcer, buttocks
- 707.06 – Pressure ulcer, ankle
- 707.07 – Pressure ulcer, heel
- 707.09 – Pressure ulcer, other site

6 new ICD-9-CM diagnosis codes for pressure ulcers have been added capturing wound severity. The new codes are:

- 707.20 – Pressure ulcer, unspecified stage
- 707.21 – Pressure ulcer, stage I
- 707.22 – Pressure ulcer, stage II
- 707.23 – Pressure ulcer, stage III
- 707.24 – Pressure ulcer, stage IV
- 707.25 – Pressure ulcer, unstageable

Coding professionals must identify two different codes to completely describe a pressure ulcer, identifying both the site and the stage. The codes for pressure ulcer stages may not be assigned as the principal or first-listed diagnosis.

Assignment of the patient's diagnosis codes is performed by the coding professional in medical records. The coder reviews all the physician's documentation in the medical record to determine what conditions the patient was treated for during the hospitalization and what procedures were performed. If the physician indicates the patient was treated for a pressure ulcer during the hospitalization, the coder will then look through the record to determine if the pressure ulcer was present at the time of admission, or if it was facility acquired. Coders may review documentation from other clinicians, including the WOC nurse, to help determine code assignment for the pressure ulcer stage. The hospital may be eligible for additional payment if there is documentation to support a Stage III or Stage IV pressure ulcer present at the time of admission. The hospital will receive no additional payment for facility acquired pressure ulcers, regardless of the stage.

Present on Admission Indicator for Pressure Ulcers:

1. Present on admission is defined as present at the time the order for inpatient admission occurs. Any condition, including a pressure ulcer, that developed during an outpatient encounter, including the emergency department, observation, or outpatient surgery are considered as present on admission.
2. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. The term “provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.
3. There is no required timeframe as to when a provider must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis, or the condition may not be recognized or reported for a period of time after admission. Determination of whether the condition was present on admission should be based on the provider’s best clinical judgment.
4. Stage III and Stage IV pressure ulcers present on admission will qualify for higher MS-DRG payment. The MS-DRG algorithm does not calculate additional reimbursement for pressure ulcers identified as Unspecified, Stage I, Stage II, or Unstageable when they are present on admission.
5. The physician is responsible to resolve inconsistent, missing or conflicting documentation issues. Coders will need to query physicians if the documentation is unclear or inconsistent.
6. If the patient is discharged with a facility acquired pressure ulcer, but later readmitted with a different diagnosis, the pressure ulcer will then be considered present on admission and may be eligible for a higher MS-DRG payment.

There are still some unanswered questions about the rule. Each facility may have differing interpretations and policies about these unresolved issues. In guiding your interpretation of the rules, we remind all members and facilities the intent of this rule is to promote the prevention of facility acquired pressure ulcers. We also recognize that all members want their hospitals to be fairly compensated for pressure ulcers that are present on admission. As CMS issues clarifications, these will be posted for our members.

Questions and answers:

1. Is there any defined timeframe for the physician to document the presence of a pressure ulcer on admission?

Answer: There is no required timeframe as to when a physician must identify or document a condition to be present on admission. Physicians should be promptly notified of all pressure ulcers detected on nursing inspection.

2. What should be coded if a patient has an unstageable pressure ulcer or suspected deep tissue injury present on admission that undergoes debridement or evolution during the hospitalization resulting in a Stage III or Stage IV pressure ulcer on discharge?

Answer: The pressure ulcer would be coded as a Stage III or Stage IV.

3. What should be coded if a nurse documents the patient presenting with a Stage II pressure ulcer, but the physician documents a Stage IV pressure ulcer?

Answer: The coder will likely query the physician about inconsistencies in the medical record.

4. The physician documents the presence of a pressure ulcer, but the WOC nurse indicates the patient has incontinence-associated dermatitis. How should this be resolved?

Answer: Identification and staging of pressure ulcers requires knowledge, skill and practice. Many physicians will acknowledge their lack of expertise and will welcome the input of the WOC nurse. The WOC nurse should document the findings and may notify the physician to offer input. A joint effort is essential to achieve accurate code assignment and reporting of facility acquired pressure ulcers.

5. A patient presents to the hospital with a stable black heel eschar. The eschar is successfully maintained, and the patient is discharged with the same unstagable pressure ulcer. What should be coded?

Answer: The code assignment would be 707.07 Pressure Ulcer, heel and 707.25 Pressure Ulcer, Unstageable.

6. A patient presents to the hospital with a healing Stage IV pressure ulcer. How should this be documented and coded?

Answer: In order to document a Stage IV pressure ulcer present on admission in this case, a thorough history of the wound must be known and documented in the medical record by the attending physician.

7. What happens when there are multiple pressure ulcers of varying stages, some of which were present on admission, and some that were facility acquired?

Answer: The coder will have to review the documentation to clearly determine the location and stage of each pressure ulcer, and then determine if each specific wound was present on admission.

8. The nurse documents the presence of a pressure ulcer present on admission, but the physician fails to document the diagnosis, despite frequent efforts to remind them.

Answer: Coders or compliance officers may query the physician about the presence of a pressure ulcer. Accurate diagnosis must be based on physician documentation. Nursing documentation may be used only for code assignment of the pressure ulcer stage.

9. Does this regulation imply that the WOC nurse needs to assess and stage all pressure ulcers for accuracy?

Answer: We recognize that pressure ulcer identification requires education, skill and practice. Not all healthcare providers have the necessary expertise to identify and stage pressure ulcers accurately. Each hospital may have defined roles and job descriptions for the WOC clinician, and that may include the assessment of pressure ulcers. The WOC nurse has the appropriate expertise and can be utilized in the training of staff and providing clinical validation of this important skill.

10. Does wound photography meet the present on admission indicator?

Answer: Wound photography does not take the place of physician documentation and would not meet the regulatory requirement. Photography in wound care serves as an adjunct to assessment documentation and should be used to enhance or support the written wound description.

11. I am concerned about patients on observation status. Pressure ulcers can begin in the emergency room as well as in an observation bed. Shouldn't the hospital be tracking these pressure ulcers?

Answer: This specific rule relates to inpatient prospective payment. But facilities should note the intent of the rule is to promote the prevention of pressure ulcers. As hospitals develop quality improvement efforts aimed at prevention, early skin inspection and accurate documentation, it is appropriate to include emergency rooms and outpatient departments in these efforts.

12. Can coders use nursing notes or wound care flow sheets to determine the present on admission indicator or staging information?

Answer: Reimbursement will be based on provider documentation. A provider is defined as a physician, or any provider licensed to make a medical diagnosis. Nursing records and wound flowsheets, including notes by the WOC nurse, can be used by coders for information on the stage of the pressure ulcer.

13. What is the difference between an "unspecified" stage and unstageable?

Answer: Assignment of code 707.25, Pressure ulcer, unstageable is used for pressure ulcers whose stage cannot be clinically determined and pressure ulcers that are documented as deep tissue injury. This codes should not be confused with the 707.20, Pressure ulcer, unspecified stage, which should be assigned when there is no documentation regarding the stage of the pressure ulcer.

14. What about pressure ulcers that are unavoidable?

Answer: CMS and CDC have not identified clinical criteria for unavoidable pressure ulcers.

For further review, the regulations can be accessed at the following websites:

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3820.pdf>

<http://www.cdc.gov/nchs/datawh/ftpserv/ftp/cd9/icdguide07.pdf>

<http://edocket.access.gpo.gov/2008/pdf/08-1135.pdf>

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>