

# Pressure ulcer medicare payment essay sample

[Health & Medicine](#), [Hospital](#)



Medicare like all health insurers is constantly looking for ways to avoid paying for unnecessary medical care. The latest attempt sounds perfectly reasonable until you consider who will bear the burden. Problem: Last year federal centers for Medicare and Medicaid Services announced that they would no longer reimburse hospitals for treatment of new pressure sores in Medicare patients. The ruling, known as the Inpatient Prospective Payment System (IPPS) final rule, adopts a new Medical Severity Diagnoses Related Group (MS-DRG) classification system that expands the current number of DRGs from 538-745, with weighing factors that will be phased in over a 2 year period. What does this all mean: Under the new payment plan, pressure ulcers present on admission will qualify for a higher reimbursement ONLY if the pressure of Stage III or IV ulcer is noted in the medical record within 2 days of inpatient admission. Anything identified after that initial admission period will not be eligible for additional reimbursement.

Medicare's rationale is that by refusing to pay for a "never event" it will reduce the number of mistakes. They claim that the "never event" is a mistake so easy to prevent that it should never happen. Don't have Medicare and think this does not affect you, well it does, most private insurers usually adopt Medicare rules eventually. However, Medicare still pays for errors on wrong site surgeries which seem like a "never event" that should top the list as PREVENTABLE! What are pressures and are they really preventable: The medical term Decubitus Ulcer, Decubitus mean's "lying down" simply implies only a single etiology for these lesions, yet their pathogenesis also includes, at least, friction, shear force, moisture, temperature elevation, sensory impairment and oxygen deprivation. When you think of the word

pressure ulcer, what might come to mind is “ Neglect” and when you see how atrocious some pressure ulcers can become, the word “ Neglect” takes on a new meaning.

It’s not always about being neglected; some patients have preexisting conditions that predispose them to being candidate’s for acquiring pressure ulcers outside the realm of the word “ Neglect” Have you considered these patients being at risk for the development of a pressure ulcer and they also top the list of not being able to heal if a pressure ulcer was to develop. \*

Patients with Peripheral Vascular problems- diabetes, HTN, Hypercholesterolemia, Smokers, Hypotension, Hypoxia \* Gastro Disease patients – Anyone who has problems with Malabsorption, poor absorption of nutrients or patients with CDiff – diarrhea only takes 45 minutes to sit on the skin before skin breakdown starts to occur. \* Malignancy patients- cancer patients develop weight loss and sometimes don’t absorb nutrients needed to keep skin from breaking down \* End Stage Renal disease patients – Protein energy decrease and results in malnutrition, anorexia, muscle wasting and decreased wound healing.

\* Patients on life support measures like ventilators, tubes, catheters, IV tubing makes repositioning challenges. \* Studies show that 3 hours on a stretcher waiting to be seen, and tissue wasting may already have begun. Hospitals are still learning about it and trying to identify under what, if any, circumstances these pressure ulcers can be rescued. Even with an increasingly sophisticated understanding of the pathogenesis of pressure ulcers recognizes both the intrinsic factors (the individual’s health) and

extrinsic factors (mechanical influences) that contribute to pressure ulcer formation. Disease processes such as diabetes, heart disease, renal disease, dementia, and malnutrition also enter the equation because they affect both the development and healing of pressure ulcers. Does Medicare understand or take into consideration the role that acute illness and the body's stress response may have on the skin? Who Pays and at what cost:

Medicare claims: The basis for the new regulation is that pressure ulcers are a high-cost, high-volume condition that can reasonably be prevented by applying current evidence-based guidelines, a view that remains controversial. In time, with adequate data, we will find out if the CMS's new pay-for-performance plan achieves the goal of fewer Stage III and Stage IV pressure ulcers. The objective is to improve patient care and reduce the number of preventable medical errors \* The cost: Average cost per stay increases from \$8000. 00-\$43, 1800. 00 when pressure ulcers extend past the average length stay. \* Medicare pays on average between 5 Billion and 8. 5 Billion in expenses each year for something they believe is preventable. \* Medicare factors in the following when determining where the additional cost are incurred. \* Nursing time

- \* Doctors visits

- \* Consults

- \* Prolonged stays

- \* Diagnostic testing

- \* Operative procedures

- \* Wound care and rehabilitation

\* Pin

\* Disability

\* DEATH

In fact because Medicare deems what is preventable and will no longer provide hospitals with reimbursement, other insurers will likely follow and millions stand to be lost. Medicare states that by not paying for pressure ulcers stage III and IV, they will save an annual of 21 million each year. Hospitals claim: They stand the risk of losing millions of dollars for what some consider to be unavoidable regardless of following protocol with pressure ulcer care. \* When the patient comes into the hospital, skin assessments must be done immediately, if for some reason the assessment of a pressure ulcer is missed and the patient is admitted the pressure ulcer now becomes the property of the admitting hospital and payment for treatment will not be reimbursed. \* You miss it upon assessment, you own it.

\* Who decides what takes precedence:

\* Cardiac life saving treatments or performing a pressure ulcer assessment. \* Sepsis treatment or pressure ulcer assessment.

\* Providing life saving treatments or pressure ulcer assessments. \* What are hospitals doing to cover the cost:

\* Many doctors are over diagnosing, meaning documenting a lot more illness, so that when your stay gets extended for a “ never event” it will be difficult for Medicare to determine what care is for a “ never event; and what care is not. \* The hospital can allege that the extended stay is due to a problem that was not a never event which means more testing, procedures and more unnecessary cost. \* If someone develops a “ never

event” pressure ulcer, the hospital can transfer you to another facility.

Hospitals will develop under written agreements that certain specialist at each other’s facility are better suited to treat certain patient’s “ never events”. This means once the patient is transferred to another facility, the problem then becomes a pre-existing condition and not the new facility can treat and receive payment. The result, more transfers, redundant testing, higher cost. The pressure is on Nurses

\* Pressure ulcers are viewed as a quality-of-care indicator. Reducing healthcare-associated pressure ulcers is both a Joint Commission National Patient Safety Goal and a goal for Healthy People, 2010. Pressure ulcer prevalence is number 2 on the National Quality Forum’s “ 15 National Voluntary Consensus Standards on Nurse-Sensitive Care.” Add to this the economic incentive and the message is clear: zero tolerance for pressure ulcers. Although it is theoretically a multidisciplinary issue, nurses, as the primary caregivers, will shoulder the burden of preventing pressure ulcers in hospitals and long-term care facilities. \* And when pressure ulcers occur, nurses will be blamed, in spite of the fact that they have little or no control over the factors that affect their ability to provide quality care, such as staffing, census, budgets, or purchasing of equipment and supplies.

\* It’s a no-brainer that staffing levels affect our ability to provide the care necessary to prevent pressure ulcers. Research shows that lower pressure ulcer rates can be achieved with a higher proportion of RN staff, and a staff mix heavier on more experienced nurses, findings that will surprise no one. In long-term care, patients who receive more direct care from RNs have

fewer pressure ulcers. Despite such evidence, a recent article describing how to reduce the pressure ulcer rates to zero does not address the need for adequate nurse staffing levels and staff mix \* Assessment is key: Upon admission: Document whether a patient has conditions covered by this program, such as pressure ulcers, when they are admitted to the hospital. \* The bottom line is careful initial assessment and documentation of the POA conditions as well as working to develop “ best” practices to improve outcomes.

Putting a positive spin on the problem: If there no longer going to pay health care facilities have to do something:

- \* Automation of the process
- \* Air mattresses
- \* Daily skin assessment reminders that are automated
- \* Protocols to prevent skin breakdown
- \* Education
- \* Prevention – Some health care facilities show that cost has decreased from 20% to 0.8 % over the past few years by adopting new protocols. \*

Implementation teams- these are used to guide the improvement efforts. \*

Wound care teams

- \* Providing high incentives to facilities with lower rates and higher incentives for those who prevent the problem from occurring all together. In conclusion: Perhaps the most important aspect of all is: Over time healthcare facilities will react in one of two ways: By either devoting more resources to improving nursing care quality, or will they respond with fiscal restraint and workforce

cutbacks that weaken the ability of nurses to maintain quality inpatient care. Either way, Medicare's refusal to pay for a "never event" is simply the latest iteration of paying for performance. However, by refusing to pay for complications that sometimes cannot be prevented, Medicare will merely shift the burden to patients, in particular, the oldest and sickest.

#### Work Cited

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