Mission possible:
Getting Medicare reimbursement for wound care in acute-care settings

Find out how the Affordable Care Act affects reimbursement—and how you can maximize your reimbursement.

By Susan Reinach-Lannan, BSOM

In the current healthcare environment, wound care practitioners need to capitalize on all available reimbursement avenues for care delivery and wound care supplies and dressings. And when it comes to reimbursement, there's one constant: The rules change constantly. Whether these changes always benefit the patient is questionable. Nowhere is this more evident than in acute-care settings. Clinicians constantly are challenged to make sure their patient-care decisions comply with current Medicare reimbursement guidelines. (And if you're not sure about today's guidelines, be prepared for the guidelines to change tomorrow.)

This issue is especially challenging for nurses who specialize in caring for wound patients. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, will force a change in provider reimbursement. Within a few years, Medicare reimbursement will be based on quality of care and clinical outcome results, not just the quantity and type of care provided. Starting in fiscal year (FY) 2013, the Hospital Value-Based Purchasing Program will apply to payments for discharges occurring on or after October 1, 2012. Hospitals will be rewarded if they meet certain quality measures defined by Medicare; hospitals that don't meet these measures will be penalized by reduced reimbursements.

Starting in FY 2013, the basic diagnosis-related group (DRG) payment amount will decrease as follows:

- FY 2013: 1% decrease
- FY 2014: 1.25% decrease
- FY 2015: 1.5% decrease
- FY 2016: 1.75% decrease
- FY 2017: 2% decrease.

While these decreases may seem small, within a hospital's overall reimbursement, they're significant and will have to be offset to ensure the hospital remains financially sound. According to Medicare, money saved by these reductions will go toward providing value-based purchasing incentives to hospitals that meet or exceed quality performance standards. In the future, the same payment plan is almost certain to carry over to long-term acute-care facilities, rehabilitation facilities, and skilled nursing facilities.

Excessive readmissions also will be scrutinized, and hospitals will have to justify these readmissions. Under the Affordable Care Act, hospitals with excessive readmissions for certain conditions, including myocardial infarctions, heart failure, and pneumonia, will see reduced Medicare reimbursements. And beginning in FY 2015, hospitals with high rates of certain hospital-acquired conditions will see lower reimbursements. One of these conditions is hospital-acquired wounds. The emphasis now is on preventing pressure ulcers, especially stage III and stage IV pressure ulcers in hospital patients.

Reimbursement tips

But not all is lost. Clinicians and facilities caring for patients with wounds will still be able to get reimbursed as long as they pay attention to detail. To maximize reimbursement, follow these tips:

1. Help ensure that products and services used by the hospital to care for wounds are coded with the Healthcare Common Procedure Coding System (HCPCS) for Medicare reimbursement. The decision to use certain products is influenced mainly by administrators, who rely on the hospital's formulary committee to recommend the best and most cost-effective products. In some cases, the wound care team may be included in formulary decisions. Two types of HCPCS codes exist—Level I and Level II. Level I codes are used mainly for billing of services provided by physicians and other healthcare professionals. Level II codes are used primarily to identify products and supplies. Typically, most wound care products and supplies coded with Level II are used in long-term care settings. But sometimes they're used in acute-care settings, especially hospitals specializing in wound healing.
2. Make sure the patient's chart includes current laboratory results and nutritional assessments. Medicare requires patients to qualify for certain products and services. In a Medicare audit, documenting this information in the chart to show the patient qualifies goes a long way toward preventing requests for repayments. (Keep in mind that documentation is crucial. Be sure everything is documented in the patient's file. In health care, if it isn't documented, it didn't happen.)
3. Verify that wound measurements are documented and staged correctly in the patient's file. The patient's acuity level dictates the products and services Medicare will reimburse to the healthcare provider.
4. If necessary and warranted, photograph the patient's wounds and use wound assessment tools to track healing. If no wounds are present at admission but the patient is immobile or has compromised mobility, use pressure-redistribution products and strict turning schedules to prevent a "never" event. (In 2008, 39% of "never" events reported to the Minnesota Department of Health were pressure ulcers acquired after admission.) Even when state-of-the-art care

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is provided, a patient may develop a pressure ulcer. Vigilance and monitoring by healthcare providers, in conjunction with risk assessment, may help prevent pressure-ulcer development during the patient's stay, reducing the risk of a full-blown Medicare audit.

5 A good billing/coding department is a must for any healthcare organization or provider. A coder who knows his or her way around ICD9 and ICD10 codes can make or break reimbursement success. An organization can invest wisely by hiring the right billing/coding team and making sure team members have the proper software and keep abreast of relevant changes. In addition, an auditing department that can recognize potential problems with billing/coding errors up front can help prevent audits and requests for repayment by the Centers for Medicare & Medicaid Services.

Preventing and healing wounds should be a team effort. This team should include not just physicians and bedside clinicians but discharge planners and the billing/coding department. Having an excellent team not only helps to ensure the highest quality of patient care and services. It also helps to reduce readmissions, prevent wound development after admission, and maximize Medicare reimbursement. ■

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