

**JUST FOR THE RECORD**  
*Reimbursement and Litigation Risks*  
*Toni Turner, RCP,CHT, CWS*

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## Idaho PUPC

Idaho Pressure Ulcer Prevention Coalition

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**OBJECTIVES**

- ICD-10 "billable vocabulary" and coding guidelines.
- Why pressure ulcers remain on defense attorneys radar.
- Under paid claims, denials or paybacks when clinicians and coders don't speak the same language.
- "Know Thy Self" via internal (and external) routine auditing.
- The importance of customization when developing your protocols.

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THE POWER OF WORDS



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DEFINING THE PROBLEM

CONTROVERSIAL 2016 NPUAP TERMINOLOGY REVISION

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INJURY VS. ULCER

NPUAP Pressure Injury Stages

The updated staging system includes the following definitions:

**Pressure Injury:**  
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

**Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**  
Local skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis**  
Partial-thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as a fluid or fibrinous surface. Adipose tissue, fat, muscle, tendon, and bone are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from shearing microtrauma and shear to the skin over the heels and heels in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), diaper-associated dermatitis (DAD), medical adhesive-related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).

**Stage 3 Pressure Injury: Full-thickness skin loss**  
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and slough (non-viable wound) are often present. Slough and eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant edema can develop deep wounds. Underlying and tunneling may occur. Fat, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

**Stage 4 Pressure Injury: Full-thickness skin and tissue loss**

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FEAR OF INCREASED LITIGATION BY SOME

- The word “injury” connotes the concepts of safety and prevention, which may work in the plaintiff’s favor
- New staging description for “**Deep Tissue Pressure Injury**” states that such a wound “results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.” Giving the perception that patients may have been abused or neglected.

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**WHY THE WORD "INJURY"?**

- Stage 1 and Deep Tissue Injury were never ulcers
- An ulcer cannot be present without an injury, but an injury can be present without an ulcer

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**STAGING SYSTEM ENDORSED BY**

- Wound, Ostomy and Continence nurses Society (WOCN)
- Centers for Medicare and Medicaid Services (CMS) for upcoming work
- The Joint Commission
- World Health Organization for ICD-11
- Many health care organizations
- Many health care associations

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**ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING**

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FY 2019 (October 1, 2018 - September 30, 2019)	FY 2020 (October 1, 2019 - September 30, 2020)
<ul style="list-style-type: none"> <li>The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable.</li> </ul>	<ul style="list-style-type: none"> <li>The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, <b>deep tissue pressure injury</b>, unspecified stage, and unstageable.</li> </ul>

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**FOR IMMEDIATE RELEASE**

For additional information, please contact:

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**National Pressure Ulcer Advisory Panel (NPUAP) changes name to National Pressure Injury Advisory Panel (NPIAP)**

Westford, MA (November 7, 2019) – National Pressure Ulcer Advisory Panel (NPUAP) is pleased to announce that it has changed its name to the National Pressure Injury Advisory Panel (NPIAP). The new name reflects the future direction of the organization and a reaffirming of our commitment to adopt the internationally preferred term, pressure injury, in place of pressure ulcer.

A thorough review of all possible names that might be in alignment with our mission was conducted prior to the board voting to adopt National Pressure Injury Advisory Panel. The name change has been approved by the state of New York, where our organization is incorporated. We are currently working with an attorney on trademarking the acronym and logo.

The new name presents an opportunity to innovate and with that, comes our new more contemporary logo. For NPIAP, the patient will always be at the center (green core) of what we do. The sunrays emanating from the core represent NPIAP's work in reaching out to improve outcomes for patients with education, research and public policy.

The National Pressure Injury Advisory Panel (NPIAP) is an independent not-for-profit professional organization dedicated to the prevention and management of pressure injuries. Formed in 1986, the

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SO... DOES ANY OF THIS DECREASE THE RISK OF A PROVIDER GETTING SUED??

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### SHOW THEM THE MONEY...

#### Nursing Home And Assisted Living Facility Abuse Verdicts

- \$17 million** for the death of a 78-year-old woman due to starvation and a Stage IV bed sore
- \$12.3 million** for the death of a 92-year-old woman due to starvation and numerous Stage IV bed sores
- \$800,000** for the death of a 94-year-old nursing home resident due to bed sores
- \$675,000** for death due to bed sores
- \$650,000** for three Stage IV pressure sores which healed at the next nursing home
- \$600,000** for multiple pressure sores
- \$600,000** for pressure sores in an understaffed nursing home
- \$600,000** for bilateral heel pressure sores

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### ...NO SLOW DOWN IN SIGHT!



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### EDUCATED BEYOND CLINICIANS

Read on to learn the answers to three FAQs about pressure ulcer medical malpractice lawsuits:

#### 1. Do I Have Grounds for a Claim?

There are several elements that must exist for a person to have grounds for a medical malpractice claim. Those elements are:

- **Duty of Care:** The defendant must have owed you (or your deceased loved one) a duty of care. This duty of care exists as soon as the healthcare provider-patient relationship is established.
- **Breach of the Duty of Care:** If the healthcare provider failed to follow accepted standards of care, this may be considered a breach of the duty of care. In bedsores cases, this breach typically involves failing to monitor and reposition the patient regularly to relieve pressure on the skin.
- **Causation:** You must be able to prove how the healthcare provider's breach of duty caused the pressure ulcers.
- **Damage:** Finally, you must demonstrate the damages you have incurred as a result of the bedsores, which may include healthcare bills, lost income, pain and suffering, mental anguish, loss of consortium, physical impairment, and loss of enjoyment in life.

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### CONFLICTING AND/OR INSUFFICIENT DOCUMENTATION RISKS

- Inaccurate coding
- Denial for services rendered
- Pre-Authorization(s) delayed/denied
- DME supplies/equipment denials
- Perpetuation of inadequate or wrong clinical information to next care provider/facility.
- Payments recalled
- Fragile data prohibits usefulness



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### IDENTIFY YOUR FACILITIES HIGH RISK AREAS

- Lack of policies and procedures
- Not providing *ongoing* competency training and/or no records to prove it.
- Chronically under staffed
- Prior survey citations
- Lack of Compliance presence
- No internal or external auditing
- Outdated EMR macros
- Clinical staff uncertain of the coding difference between *unspecified* and *unstageable*?
- Inconsistent with request for referring provider records.
- Staff lacks uniformity in measurement and photo protocols.
- Unreliable communication/direction between staff and ordering physician

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### RECOMMENDATIONS

- Stay current and informed!
- Customize P&P for your setting (Assessment, Prevention, Transfer of Care, etc)
- Communicate with staff and administration
- Train and Retrain to strive for uniformity and consistency in documentation methodology
- Self audit and procure annual third party
- LISTEN to your patients/residents

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**Disclaimer**

The analysis of any medical billing or coding question is dependent on numerous specific facts – including the factual situations present related to the patients, the practice, the professionals and the medical services and advice. Additionally, laws and regulations and insurance and payer policies (as well as coding itself) are subject to change. The information that has been accurate previously can be particularly dependent on changes in time or circumstances. The information contained in this presentation is intended as general information only.

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