INTRODUCTION OF REIMBURSEMENT

Documentation & Coding in
Outpatient Wound Care and HBOT Centers

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SerenaGroup
Building the Nation's Leading Wound Care Team

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* This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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Changes Effective 2016:
Off campus & On Campus Clarification

Place of Service (POS) Codes for Professional Claims

S Code: 19 (added)

Place of Service Name: Off Campus- outpatient hospital

POS Description: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

POS Code: 22 (revised)

Place of Service Name: On Campus- outpatient hospital

POS Description: A portion of the hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

Why is it important to understand the Place of Service Codes?

- QHPs (Quality Healthcare Professionals); such as physicians, podiatrists, NPs, PAs and clinical nurse specialists often practice at a different POS, whether it is at an office location, hospital or HOPD. All have different POS codes.
- You must have a process in place for the “billers” to identify the appropriate POS. A POS designation dictates the Medicare fee schedule for the provider.
- Do not run the risk of overbilling Medicare

General Recommendations

- Be ready to embrace and be open minded in preparing for the rules and regulations of wound care and hyperbaric medicine under the guidelines of the OPPS (Outpatient Prospective Payment System).
- For practitioners/providers, this is not an extension of your current scope of practice. This is an advanced modality setting, with specific rules and guidelines, which requires adherence to current practices with regard to billing, coding and documentation requirements.

Helpful Tips

Q: I am a program manager, clinician/assistant, front office staff, HBO tech., or physician. Do I need to be aware of reimbursement, coding, scheduling, etc.?

A: **It is important that all staff in a wound care center are knowledgeable of aspects of a functioning clinic. Every role in the clinic can be beneficial for successful patient interaction and patient experience.**

- Billing/coding/documentation/scheduling/registration process, is at the heart of every outpatient wound care /hyperbaric visit, and is key to the financial success of the program.
- Without a financial/compliance understanding, we may be offering costly treatments/procedures, when there may be a more effective and less costly treatment option. What if you missed obtaining a pre-cert.? If you have not documented medical necessity or appropriateness, then the chance for denial is eminent. If the claim is paid, do not interpret this as a guarantee. A RAC audit or request for Additional Documentation Request supporting documentation may reveal a lack of adequate supporting documentation, and the monies may be paid back, denied, or even placed on Medicare review process.

Common Terms

New Patient: A person that has not had any service provided by your hospital within the past three years.

Established Patient: A person that has had a visit to your hospital or facilities within the past three years.

- *you may have a patient that is new to your wound care/HBO center, but for billing purposes, it is an established patient.*

Common Terms Cont.

CPT Code: (Current Procedural Terminology). CPT is a registered trademark of the American Medical Association (AMA). The CPT code set is a "medical code set" maintained by the AMA and describes medical, surgical and diagnostic services as designed to communicate uniform information about medical services and procedures.

ICD-10-CM: (International Classification of Diseases, Tenth Revision, Clinical Modification). It is the current system used in the United States as of late 2015 to classify or assign codes to health related conditions and related information. The code(s) may be entered into a patient's electronic medical record, and used for diagnostic, billing and reporting services.

Common Terms Cont.

LCD: Local Coverage Determination

NCD: National Coverage Determination

APC: Ambulatory Payment Classification. The hospital is reimbursed based on APC rates as set by Medicare. APC rates are groups of similar services that are priced the same.

OPPS: Outpatient Prospective Payment System. Mandates our Medicare/payer source billing rules.

HOPD: Hospital-based outpatient department. Our centers are a HOPD.

Denial: Hospital may not be paid or reimbursed for a patient date(s) of service, based on documentation submitted for payment. Timely review of documentation and responding to specific requests is crucial. Correct, resubmit or appeal ASAP.

What is a modifier?

Modifiers: alters the description of a service without changing the intent of the service provided. It is a two digit alpha or numeric descriptor that is appended to the end of a HCPCS/CPT code to clarify the services billed.

Commonly used modifiers:

-25 Significant, separately identifiable E/M

-50 Bilateral procedures

-54 Surgical Care Only

-55 Post Operative Management only

-58 Staged or related procedure during postop period

-59 Distinct procedural service

-79 Unrelated procedure or service by same physician during the postop period

Modifier -59 applies a 50% discount to each procedure after the first one

-XU/XS Subset of the 59 modifiers

Debridement- Selective

Debridement is based on area debrided, not total ulcer size!!!! Must include a Time Out performed, if excisional.

Selective (CPT Codes 97597-97598) The physician removes no living tissue. Usually there is no mention of bleeding (which indicates living tissue).

97597 The removal of nonviable tissue, first 20 sq cm or less

97598* each additional 20 sq cm, or part thereof

Should include the following elements:

- *Location and characteristic*
- *Type or description of tissue removed*
- *% (surface area) of the ulcer debrided*
- *Instrument used (may be sharp)*
- *Patient's tolerance*
- *Dressings applied and treatment plan*
- *Depth should be minimal*

*= Bundled

Debridement - Excisional

CPT Codes 11042-11047

11042 debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less.

11045* Each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure).

11043 debridement, muscle and/or fascia(includes epidermis, dermis and SQ tissue) first 20 sq cm.

11046* debridement muscle, each additional 20 sq cm.

11044 debridement bone, includes (includes epidermis, dermis, sq. tissue, muscle/fascia) first 20 sq cm.

11047*debridement bone, each additional 20 sq cm.

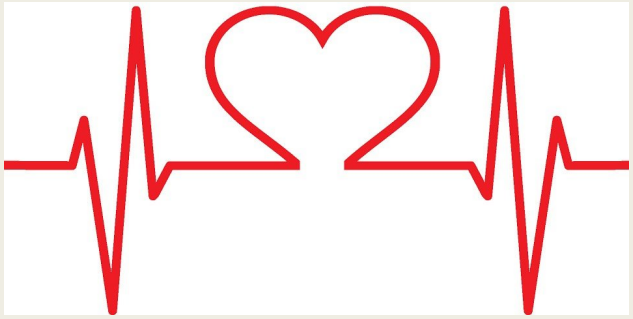
* CPT codes not underlined are bundled

Debridement - Excisional Cont.

Excisional Debridement should include the following elements:

- Medical decision to perform procedure
- Location and characteristics of wound
- Type of tissue removed (eschar, fibrin, bone, etc.)
- Depth of procedure
- % of the surface area of the ulcer debrided
- Amount of bleeding and how it was stopped
- Instrument used and size of instrument
- Patient tolerance and pain control
- Dressings applied and treatment follow-up
- Pre and post debridement measurements

WAGNER CLASSIFICATION



Grade:	
Zero:	No ulcer
One:	Superficial skin ulcer without penetration to deeper layers
Two:	Deeper ulcer penetrating through dermis. Tendon, ligaments, joint capsule or bone may be exposed
Three:	**Deep ulcer with abscess, osteomyelitis, pyarthrosis, plantar space abscess or infection of the tendon or tendon sheaths**
Four:	**Localized gangrene – forefoot, toes or heel, which may be wet or dry**
Five:	**Gangrene of the foot**

Common Causes of Denials

- Incorrect patient identifier information
- Missing or invalid CPT/HCPCS codes
- Invalid or missing ICD-10-CM
- Requires prior authorization or precertification
- Request for medical records
- Services not covered
- Timely filing
- No referral on file
- Coordination of benefits
- Coverage Terminated

Why do our patients receive two bills?

- ❑ One bill for the physician/provider service/**professional fee**
- ❑ One bill for the hospital cost/**facility fee**

- Facility receives payment
- Physician receives payment
- Physician payment reflects facility use
- Patient co-pay to both facility and physician

YOU MUST DISPLAY OR GIVE A PATIENT WRITTEN NOTICE OF YOUR BILLING PRACTICES

Questions & Answers

Question. What if we have a patient that is new to our center, but has been provided a service by our hospital within the past three years. Do I bill for a NP (new patient) or EP (established patient) visit?

Answer. For hospital billing, this would be billed as an established level of service visit or E&M (Evaluation and Management).

Question. So, we have determined that this is an EP visit with the scenario above. What if the MD also performs a debridement, can this also be billed in addition to their E&M?

Answer. Yes. Because this is the patients initial visit to our center, and the MD will be providing a H&P, treatment plan, etc., both services can be billed. A modifier -25 would be appended to the E&M.

Questions & Answers

Question. When the patient has a subsequent visit to our center, and they also have a debridement , can we bill for an E&M and debridement again?

Answer. No, not typically. If it is just a follow-up visit with nothing new that has to be addressed, you can only bill for the debridement.

Question. What if the patient returns for a subsequent visit and has a new wound and the original wound looks infected? The MD cultures the original wound, debrides the new wound and documents a treatment plan. The nurse also obtains the new wound measurements and other documentation. Can we bill both the E&M and Debridement.

Answer. Yes. Because there is a new problem and there is supporting documentation. And you must include the modifier 25 on the E&M code.

Questions & Answers

Question. Let's say we have a NP to the center for an initial visit, but for billing purposes it is an EP because they have had services provided by our hospital within the past three years. On our daily census report do I count this visit as a NP?

Answer. YES

Question. What if we discharge a patient as healed and they return to our center in one week with the same wound. Do I count this as a NP or EP?

Answer. Rule of thumb: This would be considered an EP visit. If the time lapse between visits would have been 30 days or greater, it can be considered a NP visit. If this same patient had returned in one week with a new wound, then it is considered a NP visit.

Questions & Answers

Question. When is it appropriate to bill for a chemical cautery or cauterization?

Answer. It can be billed , it if is to address granulation or hypergranulation tissue, “not as a result of”. In other words, if you perform a debridement and to stop the bleeding you use a silver nitrate stick, then you cannot bill for a chemical cautery.

Question. Do we need to photograph the wound or ulcer pre and post debridement?

Answer. Yes, it is always recommended for prolonged or repetitive debridement services (especially those that exceed five debridements per wound), or according to your MAC.

Questions & Answers

Question. As a general guideline /rule, what is expected from our scope of practice, to ensure that we have an appropriate treatment plan?

Answer. Medicare coverage on a continuing basis for a particular wound requires documentation in the patient's record, that the wound is improving in response to the treatment plan and the care being provided. It is not reasonable to continue a given type of wound care if the evidence of wound improvement cannot be shown. The supporting documentation, with each visit (weekly, etc.), within a 30 day period must show some signs of measurable improvement. If not, it requires a new approach, which may include the physician reassessment of the underlying nutritional, infection, metabolic, or vascular status and other problems inhibiting wound healing.

Questions & Answers

Ans. cont'd.

Evidence of improvement may include measurable changes (decreases), but not limited to the following:

- Infection
- Drainage (color, amount, consistency)
- Inflammation
- Pain
- Swelling
- Wound dimensions (diameter, depth, tunneling)
- Necrotic tissue/slough

Questions & Answers

Question. What is the difference between debridement and paring of a callus?

Answer. Both debridement and paring may require the use of a sharp instrument. Callus refers to the hardened area which lies above the skin, whereas an ulcer or wound sits below the skin. A selective debridement refers to the removal of devitalized tissue within an ulcer or wound. Paring of callus refers to the removal of the hardened callus tissue. In dictation, some physicians may refer to callus tissue, but may also refer to hyperkeratosis or hyperkeratotic tissue. A correct assumption, would be that this is not a selective or excisional debridement. So, if there is only hyperkeratosis or callus, then a paring of callus should be charged. If the physician removes the callus and goes on to debride the wound, then only the debridement should be billed. Please refer to your MAC for more clarification.

Questions & Answers

Ques. It is so confusing! What is the difference between coding for a wound, ulcer or burn?

Answer. Correctness and reimbursement.

Wound codes are coded 8XX.XX (ICD-9-CM), LXX.XXX (ICD-10-CM) for ulcers.

Wound codes typically

- Denotes trauma
- Acute in nature

Ulcer codes typically

- Chronic in nature
- A wound that has not healed (generally 30 days or greater) and related to a disease process

Burn codes are coded T series codes and also specify the degree of the burn as the primary diagnosis.

If a diabetic ulcer is dictated as a wound, a coder would be directed to assign the ICD-10-CM code from the SXX series. These claims would be denied for HBO and in some cases, wound care, because these are not covered diagnosis(es), especially for HBO.

Questions & Answers

Answers Cont.

This does not mean that a diabetic cannot suffer a traumatic wound. For coding purposes, once the wound fails to heal (normally 30 days), it becomes CHRONIC in nature as it relates to the disease process and CAN BE DESCRIBED AS A DIABETIC ULCER!!

In the instance of a burn, the physician must state the site of the burn, the degree of the burn, and the total body surface area of the burned tissue.

WOUND CARE COMPLIANCE

Clinical Documentation

Detailed and complete clinical documentation in the medical record is very important. It is the basis for medical necessity, continuity of care and accurate billing/reimbursement.

Wounds and other clinical details should be evaluated and described in the medical record as precisely as possible, addressing:

- Wound evaluation including site, size, area, degree, depth, acuity and other features (such as odor or tunneling)
- Previous treatment should be documented if known, and whether that treatment was successful or unsuccessful
- Documenting the underlying cause for the wound can justify patient-specific circumstances such as delayed healing in diabetics and the use of technology like negative pressure pumps
- Procedures planned and/or performed and type of provider
- Patient care plan and education

Make A Difference

- Documentation is critical and must be specific to diagnosis, within our scope of practice in the outpatient setting -e.g., the reason for the visit/problem and something that we can treat.
- Appropriate and accurate diagnosis must be documented both by staff members and physician treating the patient.
- Clinical staff members and physician documentation must support one another. Conflicting documentation may result in the denial and reimbursement for the visit.
- Facility and physician diagnosis codes must match. The diagnosis codes are “physician driven” and are based upon their medical decision and expertise.

Example of Documentation

1. Diabetic Ulcer (DFU)
   - ***Incorrect:*** *Rebecca returns to the center today for evaluation and treatment of a non-healing wound on her left foot. She does have a history of diabetes for the past ten years and is insulin dependent. Her left toe wound will be debrided today to remove non viable tissue.---------* A coder may give this visit a wound code vs. a diabetic ulcer.*
   - ***Correct:*** *Rebecca returns to the clinic today for evaluation and treatment of a diabetic ulcer of the left great toe, Wagner Grade III, which has been present for the past 45 days and is generally a non healing ulcer despite intervention-------.*

Prioritizing Diagnosis Codes

In an outpatient setting our diagnosis codes must be specific to the reason for treatment, relative to our scope of practice. The description/dictation/impression must be precise for the coders to appropriately code the visit to reflect the priority of the diagnosis codes, especially for HBO and the reimbursement of specific billable products. We must prove and document medical necessity and coding for every visit. At some point (30 days), we need to provide documented proof that the plan of care has a measurable success of improvement and if not, the plan of care needs to be reassessed.

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Question 1

Point of Service Code identification is important because:

A) it identifies where the provider is practicing and billing for services
B) It safeguards against overbilling Medicare
C) Both A&B
D) Neither A&B

Question 2

Most patients that come to the Wound Center for Care are consider NEW Patients per the definition of CMS?

Question 4

11042 is defined as a debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 50 sq cm or less.

Question 5

The wound center you work in is considered.

A) Hospital Outpatient Department
B) Physician Practice
C) AN extension of the Hospital Acute Care setting

Question 6

A common modifier we see in our Wound Center is?

A) 52
B) 25
C) 45
D) 97

Question 7

Why do our patients customarily receive two bills for services received?

A) The hospital does this as a courtesy, in the event one should get lost or misplaced’
B) One is for the Provider and one facility
C) Because the hospital bills and collects for the providers.
D) None of the above.


THE END