As we reassess our wound care services on the eve of a tremendous change in healthcare delivery, it might be useful to look back before we try to look ahead. Prior to 2000, the majority of outpatient wound care services for Medicare beneficiaries were provided in an office-based setting because Medicare did not have a formalized payment system for hospital-based outpatient wound care departments (HOPDs). Things changed on April 7, 2000, when the Centers for Medicare & Medicaid Services (CMS) defined in the Federal Register a payment system referred to as the Medicare Outpatient Prospective Payment System (OPPS). HOPDs began to emerge as a result of the new OPPS.

CMS’ goal in creating OPPS was to pay for a variety of outpatient services that were previously available only during an inpatient stay (eg, cancer centers). OPPS was created to allow patients who were not sick enough to warrant hospital admission the opportunity to receive complex services as outpatients. The services provided in HOPDs under OPPS are “provider-based” (under the direct supervision of an advanced practitioner) and are billed as “hospital services.” Although HOPD costs normally exceed those of services provided in a qualified healthcare professional’s (QHP’s) office, CMS sought to reduce overall Medicare costs and beneficiary copayments by preventing an even more expensive inpatient stay.

Since the creation of OPPS, HOPDs have opened at an incredible rate (as have many other outpatient service lines such as infusion centers and dialysis centers). With a payment system based on services and procedures performed, the metric of success for HOPDs has been the volume and payment for the services provided. Procedures often represent 75% of the HOPD’s revenue, with hyperbaric oxygen therapy (HBOT) and surgical debridements contributing the majority of HOPD revenue, followed by the application of cellular and/or tissue-based products for wounds (CTPs [old term “skin substitute”]).

The results of a recent Today’s Wound Clinic reader survey support these published data: HBOT represents 44% of the HOPDs’ revenue, followed by debridements at 37% and application of CTPs at 8%. For the past 14 years, CMS has seen what can only be described as a meteoric rise in the use of all outpatient services, making this part of Medicare spending spin out of control. CMS is now moving to gain control of the spiraling costs of outpatient services.

In 2014, HOPDs experienced several OPPS changes that attempted to control/reduce costs:

1. CMS “packaged” the payment for CTPs into the payment rate for the procedure. In other words, Medicare used to pay separately for the CTP as well as the service of applying it. Not so anymore. This payment system change dramatically altered the list of CTPs that most HOPDs are willing to purchase, favoring “less expensive” products.

2. CMS packaged all the “add-on” procedure codes into the “base codes.” Therefore, the HOPD receives the same payment rate for work on large and small wounds.

3. CMS assigned one payment rate for all levels of new and established clinic visits.

NOTE: Regardless of the new payment rate, HOPDs should still use their clinic visit level mapping system and submit the charge appropriate for the clinic visit level.

Many other cost-containment initiatives have been announced (eg, prior authorization for home use of traditional negative pressure wound therapy [NPWT] pumps and a prior authorization demonstration project in three states for HBOT). In addition, Medicare Administrative Contractors (MACs) continue to revise local coverage determinations (LCDs) with more restrictive language pertaining to the use of nearly all advanced therapeutics. Nearly every MAC has released an LCD that limits the number of certain types of surgical debridements that can be performed per wound in a calendar year.

These changes are only the beginning of a complete overhaul of OPPS from one based on volume to one based on “value.” In fact, many healthcare systems and provider groups are participating in a variety of shared savings programs such as accountable care organizations. This requires healthcare systems to break down the traditional “silos” of care.

The synopsis provide thus far explains why the HOPD of tomorrow will not look like the HOPD of yesterday or today. It may be that we will even see the demise of the HOPD as a “bricks and mortar” place and that it will become, at least in part, a “virtual wound center” within which clinicians (increasingly employed by hospitals that are increasingly employing nurse practitioners and other physician extenders) will manage patients in a variety of settings across a continuum of care (eg, acute care hospitals, long-term care hospitals, HOPDs, offices, skilled-nursing facilities, and patients’ homes). This evolution has already begun and could be nearly complete within five years. Nevertheless, wound care providers will have the challenge of working under two different Medicare payment systems — one with volume-based reimbursement and another with value-based reimbursement. Wound care professionals will be incentivized to achieve the highest quality outcomes at the lowest total cost of care (not necessarily using the lowest-cost products or procedures) with high levels of patient satisfaction.

This restructuring began with the requirement to report “quality measures.” The need for meaningful quality measures is not a trivial exercise. Under the Affordable Care Act (ACA), an increasing percentage of hospital and physician revenue will be based on these measures. While the transition may occur over the next five years, it has already begun. NOTE: The Alliance of Wound Care Stakeholders and its member organizations have worked diligently with the US Wound Registry (USWR) to create an initial suite of 12 new quality measures for wound care and hyperbaric medicine as part of the USWR’s Qualified Clinical Data Registry (QCDR). They’re...
Available at www.uswoundregistry.com/specifications.aspx.

**Areas to Consider When Reassessing Your Clinic**

**Wound Care Products, Services, and Contracts.** Begin reassessment by determining how much money you are spending on wound care dressings in the clinic. Does it make sense? Are you following evidence-based protocols? Are you finding “sandwich shop” dressings (expensive products layered together in such a way that they can’t function as intended)? Do you have duplicative products that you don’t need (eg, several brands of the same type of dressing)? Is your par level system working? Are there products that are not being used? If so, why? What products do the nurses and/or the doctors like and not like, and why? Can you take some off your formulary? How is the inventory being maintained, and is that working? How are pharmaceuticals being handled? Look at the current hospital formulary for drugs and identify what may need to be added. Consider topical and injectable anesthetics, topical creams, debriding ointments, steroids, and antifungal agents, to name a few.

Then, take the following steps:

1) Because you will be managing wounds across the continuum of care, select high-quality products. Remember, the most “expensive” products are the ones that “do not perform.”

2) Re-evaluate your dressing and advanced technology contracts and equipment leases to include all the sites of care in your healthcare system.

3) Because each MAC medical director makes its own coverage rules about CTPs, review the LCD (if one exists) that pertains to your HOPD and to your QHPs. Published clinical evidence and coverage in medical policies should help to select the CTPs that are correct for patients. Because most CTPs now have “packaged” OPPS payment by traditional Medicare, verify that you will be able to purchase the CTP, the cover dressings, and your overhead costs with the Medicare allowable.

4) If you are in a management contract, you must determine whether the contracted rate is viable in light of the reduced revenue anticipated. Think about getting your management company to “go at risk” for potential (likely) decreases in revenue.

5) Consider defraying costs by participating in clinical research.

6) Ask for an audit of facility billing to understand where you might be getting denials of payment and why.

7) If your hospital is doing “serial billing,” work with the chief finance officer to switch to “per-visit billing.”

**Perform a market analysis.** Estimate the payer mix in your market by identifying the percentage of patients with:

- traditional Medicare insurance;
- Medicare Advantage plans;
- private insurance; and
- secondary insurance.

In addition, contact the top 20 Medicare Advantage, private plans, and secondary plans that are typically purchased by the patients in your region. Ask them about the patients’ deductibles and copayment responsibilities, which seem to rise each year. For many patients, deductibles now exceed $3,000 for a family and copay percentages have also increased. You should plan for associated decreases in the frequency of outpatient visits (due to these high deductibles and copayment requirements) as well as issues with patients not being able to afford dressings for home use since they must pay “cash” for them when they have not met their high deductibles.

**Partner with the Hospital.** Learn the current diagnostic trends for the inpatient population (eg, diabetes, cardiovascular disease, those admitted with wounds), because these can help predict potential outpatient wound needs. Talk to a compliance officer to determine what the hospital is reporting for hospital-acquired conditions (HACs) and readmission rates. Why are HACs and readmission rates an argument for the value of your wound center? The Deficit Reduction and Reconciliation Act of 2005 required CMS to identify conditions that were “high cost” and/or high volume, that resulted in the assignment of a case to diagnosis-related group with a higher payment, and that could reasonably have been prevented through the application of evidence-based guidelines. CMS identified seven HACs, four of which are considered “serious preventable events” (sometimes referred to as “never events”). As an aside, these four never events are: leaving an object in the patient, performing the wrong surgery (wrong body part, wrong patient, wrong procedure), an air embolism following surgery, and transfusing incompatible blood products. Note that pressure ulcers are not on the list. Pressure ulcers are included in the list of HACs (along with surgical-site infections, catheter-associated urinary tract infections, vascular catheter infections, and injuries from falls), which might be prevented by following clinical practice guidelines. Even though pressure ulcers aren’t never events, they represent a common reason for malpractice suits due to the perception that they are always preventable as well as a source of expense to the hospital if they occur during the patient’s admission. Knowing your hospital’s reported rate of HACs, such as pressure ulcers, is an excellent way to justify the value of your wound center’s services – assuming you are willing to do some “silo busting” at your institution.

Readmissions are generally defined as a “patient being hospitalized within 30 days of an initial hospital stay.” If a hospital has a high proportion of patients readmitted within a short timeframe, it may be an indication of inadequate quality of care in the hospital or a lack of appropriate coordination of post-discharge care. The ACA has provided a financial incentive to hospitals to lower readmission rates by establishing the Medicare Hospital Readmissions Reduction Program (HRRP). Beginning in fiscal year 2013 (Oct. 1, 2012), the HRRP imposed a financial penalty on hospitals with excess Medicare readmissions.

If your hospital has a problem with readmissions and a contributing factor is related to wounds, you may have just found a compelling argument for the value of your wound center services.

**Re-evaluate Wound Care Team.**

If you haven’t talked with hospital administration lately, it’s past time to do that. Your “value proposition” is about to change from generating revenue to saving overall costs. Use the data you receive from the hospital compliance office. Then, conduct a self-assessment of your clinical team to
be sure your team can provide wound care across the continuum. If your current team cannot, identify who should be added to your wound care case management team.

**Recruit Appropriate QHPs.** Is a QHP champion already involved? QHP staff recruitment should commence with great care. Ideally, a full-time medical director, if you don’t already have one, who has a passion for wound healing and who can assist in attracting other multispecialty QHPs, should be recruited. Setting the stage for collaborative practice with the other clinicians who will be staffing the clinic creates the best scenario for success. Many MACs and private insurance companies have begun to set a high bar for hyperbaric credentialing, in some cases requiring subspecialty board certification in undersea and hyperbaric medicine.

The quality measures available through the USWR may be incredibly valuable to your facility as you look for a physician champion. Quality data reported to CMS as part of PQRS are publicly available. If a physician does not report any measures relevant to wound care or hyperbaric medicine, you may not know whether they will follow evidence-based practice guidelines. However, if they report the wound and hyperbaric quality measures available in the USWR’s QCDR, there is insight to their practice style. What’s more, the USWR reports outcomes stratified by the Wound Healing Index (WHI). Rather than artificially inflating healing rates by removing difficult-to-heal patients from the denominator, the WHI uses a validated mathematical model to stratify wounds by their likelihood of healing. That way, clinicians (and the facility) can report healing rates among patients who were predicted to fail. This is certainly a more powerful way to assess the skill of clinicians and the success of one’s program.

**Reassess Your Patients and Ideal Volume.** Re-evaluate your program to determine whether you are seeing the “right” patients. It is imperative that patients meet the criteria for medical necessity to be seen in a hospital-based facility. Your staff members could be overworked and tired if they’re seeing patients who should not be there (eg, healthy patients with second-degree burns, patients who need sutures removed, patients whose wounds have healed just to “check on them”). Discharge patients (to the primary care physician) who do not meet medical necessity for HOPD care. Then, reassess HOPD volume to determine staffing needs.

**Reassess Staff Needs.** Once you know which services you will offer and have a better grasp of volume (patient volume is likely to be less than the previous year), it’s time to consider what type of staff and how many staff members are needed. HOPD patients are complicated (they are supposed to be). Many times, critical-care nurses, who bring with them wonderful expertise, are ready for a change from the pressure of the ICU and find wound care gratifying. You may not be able to hire experienced staff, so plan how you will train staff. Ultimately, a core group of internally recruited and nurtured experts with a cadre of assistants-in-training will go a long way in meeting financial goals for staffing as well as providing for permanence and stability. Consider staff members who can work flexible schedules and how you might share staff with other departments, and vice versa (ostomy nurses at the hospital, infusion nurses, etc.) to adjust to changes in demand for services and the “virtual wound center” that you are likely to develop.

**Provide a Well-Designed and Equipped Physical Plant.** If you are just opening an HOPD, remember that clinic space must include individual treatment rooms with sinks, adequate front office space, offices, large waiting area, adequate clinical workspace, storage areas, and clean and dirty utility rooms. If plans include hyperbaric services, changing rooms will also be needed in addition to oxygen supply, fire safety, floor weight-loading, and consideration of wax on the floor and the types of lights in the ceiling. Early in the planning, it is imperative to consult with individuals qualified to assist with these unique requirements. Remember that “point-of-care” (POC, in the room with the patient) charting is now the standard, and while a doctor’s office may be vital to smooth operations (eg, discussions with staff, administrative duties), “dictation rooms” are a thing of the past.

**Treatment room equipment.** Podiatry chairs or stretchers, Mayo stands, visitors, or disposable equipment would be more effective, depending on financial resources.

**Office equipment.** Copier(s); fax machine(s); scanner(s); locking file storage, desks, or cubicles; phones; and all other essential office needs must be considered. POC electronic documentation will require a computer in each room.

**REASSESS OPERATIONS**

There are new HIPAA regulations, and breaching them can result in staggering fines. Your staff needs new HIPAA training and you will need many new policies and procedures, including action plans for a breach in protected health information, posting new HIPAA notices, etc. Start this process with a call to compliance.

**Front Office Functions.** Review how walk-ins, registration, insurance verification, money collection, check-in and check-out processes, billing reports, payroll and timesheets, and end-of-month reporting are being handled and whether all components are working properly.

**Regulatory Compliance.** A thorough understanding of federal and state regulations, Joint Commission requirements, and payer coverage guidelines is essential to the financial health of the HOPD. Read your Medicare carrier’s LCD cover to cover and make a list of all regulatory issues raised. Many LCDs are now mandating things not to be done, things to be done, or required to be done. Do not duplicate.
such as HBOT accreditation, Advanced Cardiovascular Life Support certification for nurses, continuing education hours for doctors, and many other detailed requirements. How will you ensure these are followed? How will you convey to the carrier that you have met them?

**Documentation/Coding/Billing.**

To be paid correctly, you must code correctly. And to do this you must document correctly. Ask yourself, when was the last time you checked all the codes, billing units, and charges in your chargemaster? It is almost certain that something on your chargemaster is incorrect. Then, ask yourself if the documentation in your medical records is strong enough to support medical necessity and the codes that you are reporting to the payers. For example: Some LCDs mandate as many as 24 different elements of documentation to ensure all Medicare requirements for payment are satisfied. In addition, debridement coding requires detailed wound measurements and, in some regions, photographs before and after debridement.

Nearly all hospitals have adopted electronic health records (EHRs), but none are designed for wound care documentation and many have no method to archive photographs, necessitating a separate method of photo storage. You must create a written policy for your designated record set to ensure that hyperbaric notes, wound care notes, and photographs can all be pieced together if they do not reside together. The topic of electronic documentation in wound centers is complex and even controversial. However, CMS has made it clear that POC documentation is the standard in order to take advantage of clinical suggestions and warnings of drug interactions, etc. with electronic prescribing.

It is important to remember that documentation must include patient consent for treatment and photography. It must also include a file-based representation of “today’s” visit, which is stored in an unalterable way. This means that once the record is signed off, some sort of “visit note” (history and physical, treatment note, procedure note, etc.) will be generated and stored securely in a patient file. The EHR must also be able to produce audit logs that indicate how entries may have been changed, who changed them and when. Electronic systems can be used to track outcomes, build reports, communicate with referring physicians, and evaluate physician adherence to quality guidelines. The HOPD of the future will be gathering and following data from many sites of care and QHPs will be managing patient care and clinical practice guidelines in new ways. The concept of “spin-off dollars” will disappear. The HOPD of the future will be the hub of an operation that will help hospitals manage risk.

If your EHR does not offer electronic prescribing, then it is probably not certified under Meaningful Use. Remember: Just because your vendor has an EHR product that is certified for Meaningful Use does not mean that this is the software version you are currently using. Why does this matter? Quality reporting requires the transmission of a specific type of document file to CMS. Only EHRs certified under Meaningful Use can achieve this transmission. Ultimately, you must work with your EHR vendor to ensure the necessary quality measures are available in the EHR.

Caroline Fife is clinical editor of TWC and chief medical officer at Intellicure Inc., The Woodlands, TX.

References can be found at www.todayswoundclinic.com