Determining the Validity of Your Outpatient Wound Center

So, you’re planning to open an outpatient wound clinic? Are you sure your clinic meets the appropriate criteria to open its doors? Read on to determine just how “ready” your facility needs to be.

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On April 7, 2000, the Centers for Medicare and Medicaid Services (CMS) (then named the Healthcare Financing Administration) issued requirements for provider-based departments and entities as part of the final rule that implemented the Prospective Payment System for Outpatient Hospital Services (OPPS). From the payment perspective, “provider based” means the entity is considered part of the hospital and services furnished within that entity may be billed as “hospital services.” Historically, this meant the provider-based unit could appear on the hospital’s cost report and receive an allocation of the hospital’s overhead costs. Wound care and hyperbaric medicine are examples of the types of services that are commonly found in a provider-based setting.

What was the CMS goal with this rule? The OPPS was established to fund a variety of outpatient services that were previously available only during an inpatient stay. The goal of the program was to allow patients who were not sick enough to warrant hospital admission the opportunity to receive complex services as hospital outpatients. Just like the inpatient setting, patients in the hospital-based outpatient department (HOPD) accrue charges for both the physician service and the “facility” (hospital).

As a result, the cost of care for patients seen in an HOPD is typically higher than if they were seen in a private physician’s office. Although these additional costs normally exceed those of services provided in a doctor’s office, the goal of CMS was to reduce overall beneficiary costs by limiting or preventing an even more costly inpatient stay. To be covered in an HOPD, Medicare beneficiaries must pass the test of “medical necessity,” meaning they must require a higher level of care than can be delivered in a doctor’s office. A future issue of Today’s Wound Clinic will discuss the issue of medical necessity for wound center services in more detail.

This article is intended to help clinicians who are launching an outpatient wound clinic assess whether or not their clinic can function properly as an outpatient center from Day 1. (For an assistive reference to help guide the wound clinic director through the maze of wound clinic competence, see our Getting Ready Checklist in this issue on page 20.)

DEFINING “HOSPITAL PROVIDER-BASED OUTPATIENT CENTER”

What constitutes a provider-based outpatient wound center? Does it have to do with physical location, staffing, or only the way services are billed? Some wound centers are physically located within hospital walls and some are located in office settings. This topic is actually very complex, but we will mention a few important points: Only licensed hospitals can provide services under the provider-based rules. CMS reimburses hospitals for outpatient therapeutic services only if those services are furnished in the hospital or a department of a hospital that has provider-based status in relation to the hospital. [Federal Register. 42C.F.R. § 413.27(a)(1)(iii)]

The “entities” (let’s call them wound centers) eligible for payment under OPPS are those that bill for outpatient services using the CMS 1450 form (UB04). Thus, therapeutic services — as opposed to diagnostic services — may not be furnished under arrangements in a nonhospital setting and billed by the hospital as outpatient hospital services.

Wound centers can be either “on campus” or “off campus” with regard to the hospital. “On campus” is defined as the physical area immediately adjacent to the provider’s main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings; and any other areas determined to be part of the provider’s campus on an individual basis by the CMS regional office.

To meet provider-based criteria in an “off-campus” setting, the location of the facility or entity must be located within a 35-mile radius of the center or critical access hospital that is the potential main provider.

A facility or organization is not entitled to be treated as provider-based simply because it believes it is provider-based. A formal process is available to providers who wish to attest to provider-based status and receive an official determination from Medicare that the outpatient clinic meets the necessary criteria to bill as such.

However, currently, attestation is optional and many hospitals have not submitted an attestation. If a provider does not submit an attestation and it is later determined by Medicare that the provider was not eligible for provider-based billing, a recoupment of past payments may be required. CMS may allow a facility a period of time to come into compliance with any deficiencies, entirely at CMS discretion.

CONSIDERING COMPLIANCE

All hospital staff members working in the wound center provide services under the direct supervision of an advanced practitioner (AP) (ie, physician, podiatrist, or nurse practitioner). The practitioner can be employed by the hospital or in private practice.

This topic is a complex one. Providing a few examples of misconceptions can help:

There have been cases in which providers’ alleged failures to satisfy provider-based criteria have given rise to charges via the False Claims Act. What does that mean? If there is no AP directly supervising at all times in the wound center, no services can be provided by anyone.

The concept of a “nurse only” visit may be viable for some services, such as changing a negative pressure
wound dressing, but the AP still has to be immediately available to on-campus clinics and physically inside the building for off-campus clinics at all times, even if he or she did not see the patient. In other words, if there is no AP who can immediately step in and take over, then no services can be provided.

Unfortunately, Medicare used the words “incident to” in two different situations, and this has caused great confusion with regard to physician billing and supervision. Within OPPS in the wound center environment, “incident to care” rules mean the patient care has to be conducted under direct supervision of an AP.

However, this is different than the “incident to payment” rule in private practice for the physician, which is part of Medicare Part B regulations. When a physician employs a staff member in his/her own office under the Part B payment rules, he/she can bill for services provided by staff as if the physician performed the service.

It is important not to confuse the “incident to care” rules of OPPS with the “incident to payment” rules of Medicare Part B.

It has come to CMS officials’ attention that there is a high volume of hospitals billing provider-based services. However, these hospitals may not all be compliant with the requirements already described.

Since there is a high risk of noncompliance, CMS intends to scrutinize facilities more closely in the future through audits. (For more information on auditing, refer to TWC Vol. 6 No. 6.) The recently released changes to OPPS rules proposed a unique modifier to be reported on off-campus provider-based claims, but was not implemented due to the fact that hospitals have such difficulty appending modifiers of any kind on their claims.

CMS is evaluating other options such as the development of a new revenue code or place-of-service code that will be unique to the provider-based status. The take-home message: Facilities must be compliant with provider-based rules.

The physician’s place of service (POS) must be reported as POS 22 (hospital outpatient). Medicare reduces the physician’s payment rate in this setting in consideration of the fact that he or she does not have to pay overhead or nursing salaries when practicing within the hospital setting. If physicians fail to report the POS correctly, this is considered an overpayment by Medicare.

There have been cases of wound center-based physicians having to repay substantial sums to CMS as a result of incorrect POS designation.

It is important to know that physicians who work in HOPDs do not have to “rent” space, or otherwise pay overhead to the hospital. The hospital is not able to provide services under OPPS unless the AP is physically present. Therefore, the physician does not have to lease space from the hospital in order to have adequate facilities to care for patients in the hospital clinic setting, or to attend to administrative duties related to that service.

A lease between the physician and hospital may be required if the physician is utilizing office space for services unrelated to the wound center (eg, physician-employed billing staff). Remember, the physician’s revenue is reduced by CMS to account for the fact that the hospital has provided the necessary infrastructure for operations.

**SOME RULES THAT APPLY TO PROVIDER-BASED STATUS:**

1. The wound center operates under the same license as the hospital.
2. Clinical services are fully integrated with those of the hospital, with common privileges, quality assurance, and monitoring (as is for any other hospital department).
3. Medical records for patients treated in the facility or organization will be integrated into a unified retrieval system (or cross-reference) of the main provider. This means that those professionals practicing at either the main provider or the provider-based site must be able to “obtain relevant medical information about care in the other setting.”
4. The financial operations of the wound center are fully integrated within the financial system of the main provider and costs are reported in the main provider’s cost centers.
5. The location is held out — by signage and otherwise — to the public and payers as part of the main hospital.
6. The on-campus wound center has to comply with the same requirements of the Emergency Medical Treatment & Labor Act and billing rules applicable to HOPDs.
7. The hospital must indicate POS 22 (outpatient) and bill type (13X) consistent with OPPS. (The charges should be processed through the current outpatient code edits and not through inpatient code edits.)
8. All hospital staff members working in the wound center provide services under the direct supervision of an AP.

There are many steps that need to take place prior to a wound center’s opening to ensure the applicable rules and regulations have been complied with, otherwise hospitals and physicians run the risk of submitting improper claims for the services they render.

Are you sure you are planning to open an outpatient wound center?

Better confirm.

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