In August 2000, the Center for Medicare and Medicaid Services (CMS) created the hospital Outpatient Prospective Payment System (OPPS). CMS projected that in 2013 the cost of services provided to Medicare beneficiaries under OPPS would be approximately $48 billion. Services provided under OPPS are rendered in a “provider-based setting,” which means that an advanced practitioner must be present for the hospital to bill for these services. One could argue that, from Medicare’s perspective, “wound centers” do not actually exist as unique entities. Despite the vital services provided within them, wound centers represent only a small portion of the services provided under OPPS since this program also includes (for example) services provided in hospital emergency departments, outpatient radiology, and outpatient oncology. In fact, it may be useful to keep in mind the other services provided under OPPS as we consider who the “right” patients are for the hospital-based outpatient wound care department (HOPD). This article will help wound center directors and providers determine whether or not they are caring for appropriate patients as determined by their “medical necessity.”

ASSESSING OPPS AGENDA

What was the goal of OPPS when Medicare launched this program nearly 15 years ago? The OPPS was established to fund a variety of outpatient services that were previously only available to patients 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 as with the inpatient setting, patients in any HOPD accrue charges for both the physician service and the “facility” (hospital). This holds true for the wound center.

As a result, the cost of care for patients seen in an HOPD is typically higher than if the patients were only seen in a private physician’s office. Although these additional costs normally exceed those of services provided in a doctor’s office, the overall intention of CMS is to reduce overall beneficiary costs by limiting or preventing an even more costly inpatient stay by providing an advanced level of outpatient care that would not typically be available in a physician office setting. In other words, we are not supposed to
see patients in the wound center who could just as easily be managed in a doctor’s office. To justify being seen in the wound center, a patient’s condition must pass the test of medical necessity for that service and be in need of the higher level of care delivered in a provider-based setting.

**DETERMINING MEDICAL NECESSITY**

So, why do HOPD wound care providers really have to concern themselves with medical necessity? In 2013, the Office of the Inspector General’s (OIG) Work Plan, a roadmap for scrutiny and enforcement, included a review of physician billing in the provider-based setting.

In other words, the OIG is going to pay special attention to the physician billing taking place in the setting of OPPS, and that includes what we refer to as “wound centers.” So, that means it is time for wound care physicians to review the true medical necessity of the services provided to patients in their HOPDs as well as the written scope of practice for their facilities in expectation of increased scrutiny from the OIG. Consider the following as a guide:

**Is your clinic a true HOPD and how can you tell?**

Before we discuss which patients are appropriate for our services, perhaps we ought to define a provider-based outpatient wound center. Consider location: Some wound centers are physically inside hospitals and some are located in office buildings. This topic is actually too complex to be properly dealt with here, but we will mention a few important points. (For more on this topic, consult “Determining the Validity of Your Outpatient Wound Center,” TWCVol. 8 No. 1.) Only licensed hospitals can provide services under the provider-based rules. The entities (let’s call them “wound centers”) eligible for payment under the OPPS system are those that bill for outpatient services using the CMS 1450 form (UB04). Here are some of the rules that apply:

1. The wound center operates under the same license as the hospital.
2. The clinical services are fully integrated with those of the hospital, with common privileges, quality assurance, and monitoring (as for any other hospital department).
3. 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.
4. The location is held out – by signage and otherwise – to the public and payers as part of the hospital.
5. The wound center has to comply with the same requirements of the Emergency Medical Treatment & Labor Act and billing rules applicable to HOPDs.
6. The hospital must indicate the place of service (22 - outpatient) and bill type (13X) consistent with OPPS. The charges must be processed through the current outpatient code edits and not through inpatient code edits. This topic is too large to properly address in this article, but failure to understand the difference between inpatient and outpatient charge rules is the most common cause for claim denial.
7. All the hospital staff working in the wound center provides services under the direct supervision of an advanced practitioner. The practitioner can be employed by the hospital or in private practice.

**Seeing your wound center as payers see you.**

It’s important to understand the two distinct sets of rules that govern both the care provided and the reimbursement rules for Medicare patients who are seen in the outpatient setting. Provider-based rules govern the operational setup of the wound center. OPPS rules govern the payment mechanism designed to fund that setting. Medicare has designated local contractors (Medicare Administrative Contractors [MACs]) to help facilitate OPPS rules. MACs issue the medical policies that providers must use to ensure appro-
Appropriate patient selection is being made and specific coding and billing requirements are being followed. There may be a contradiction between the type of patients that your MAC expects you to treat and the patients your center is actually treating.

Just to be clear, the local coverage determinations (LCDs) issued by the MACs do not prevent HOPDs from performing services, they simply determine which services are covered. If a patient who does not meet LCD coverage criteria wishes to continue receiving services at an HOPD, the HOPD can give the patient an advanced beneficiary notice and the patient can pay for the service.

Objectively understanding the difference between what we believe is right to do for our patients and what is reimbursed from a regulatory standpoint can be very difficult. For example, many clinics will continue to follow a patient in the wound center long after the wound is healed, simply to assist with the application of stockings or similar preventive measures. While it may be true that preventive care is cost saving and that some patients have few logical alternatives for treatment, many, if not all, LCDs specifically preclude this type of care in an HOPD. Wound care providers must take a concerted look at their mission and scope of practice through the lens of the payers. If you do not understand the implications of the review by the OIG mentioned above, let’s state it another way: Failure to follow the regulations regarding the type of patient conditions that qualify for payment under OPPS is a potential fraud issue for the hospital and the clinicians involved. MACs and their LCDs specify the unique conditions that must be present in a Medicare beneficiary to justify reimbursement for wound care services in a provider-based setting. As more expensive and advanced therapies are

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**HOSPITAL OQR MEASURES FOR 2014, 2015, & SUBSEQUENT YEAR PAYMENT DETERMINATIONS**

**Note:** OP = Outpatient

**OP-1:** Median time to fibrinolysis

**OP-2:** Fibrinolytic therapy received within 30 minutes

**OP-3:** Median time to transfer to another facility for acute coronary intervention

**OP-4:** Aspirin at arrival

**OP-5:** Median time to ECG

**OP-6:** Timing of antibiotic prophylaxis

**OP-7:** Prophylactic antibiotic selection for surgical patients

**OP-8:** MRI lumbar spine for low back pain

**OP-9:** Mammography follow-up rates

**OP-10:** Abdomen computed tomography (CT) – Use of contrast material

**OP-11:** Thorax CT – Use of contrast material

**OP-12:** The ability for providers with health information technology to receive laboratory data electronically directly into their qualified/certified electronic health record system as discrete searchable data

**OP-13:** Cardiac imaging for preoperative risk assessment for non-cardiac, low-risk surgery

**OP-14:** Simultaneous use of brain CT and sinus CT

**OP-15:** Use of brain CT in the emergency department (ED) for atraumatic headache*

**OP-17:** Tracking clinical results between visits

**OP-18:** Median time from ED arrival to ED departure for discharged ED patients

**OP-19:** Transition record with specified elements received by discharged ED patients**

**OP-20:** Door-to-diagnostic evaluation by a qualified medical professional

**OP-21:** ED-median time to pain management for long bone fracture

**OP-22:** ED-patient left without being seen

**OP-23:** ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT scan interpretation within 45 minutes of arrival

**OP-24:** Cardiac rehabilitation patient referral from an outpatient setting ***

**OP-25:** Safe surgery checklist use

* Public reporting of measure OP-15 has been postponed. Refer to the imaging efficiency measures for more information.

** OP-19 has been removed; however, submission of a “non-blank” value is required through fourth quarter 2013 encounters.

*** As of July 8, 2013, CMS had reported a proposal to remove OP-24 due to “continued difficulties with defining the measure care setting that would enable hospital outpatient departments to collect information on patient referrals without creating undue burden on providers.”
RECOGNIZING MEDICAL NECESSITY RED FLAGS

A variety of Outpatient Prospective Payment System (OPPS) payment rules impact the wound center, thus there is no single regulatory document that provides a list of “do’s and don’ts” regarding appropriate wound care patients. Different rules apply for different scenarios. We provide some problematic scenarios here. Do any of these examples sound familiar?

1) You are referred an emergency department (ED) patient, a young adult who had sutures placed two days prior. Is it appropriate for this patient to be followed up on in the HOPD wound clinic?
   a. If the patient is otherwise healthy and has no medical problems, then no, he/she is probably not appropriate for the HOPD setting and should go to a primary care provider (PCP) for this service.
   b. However, if he/she is frail and living with multiple active comorbid diseases with a complex injury who will require close monitoring since the wound is not likely to heal normally and may ultimately have skin loss with an open ulcer requiring advanced therapeutic intervention, then the patient’s overall condition resulting in poor healing may meet the criteria for your center if documented clearly enough. The ED physician, as well as the wound care doctor’s notes, should reflect the above history and why this complex patient requires the center’s unique services.

2) Your patient’s diabetic foot ulcer closed one month ago. You have continued to see him every two weeks to make sure he is doing well. He has a history of nonadherence with his diabetic footwear and he does better if you keep an eye on him. Is it appropriate to monitor him in the HOPD?
   a. No. While it may be acceptable to see a patient once to ensure final wound closure, ongoing monitoring of healed or closed wounds is an inappropriate use of OPPS funding. These services can and should be provided by the PCP.

3) You are referred a patient with a surgical wound who is still within a 90-day global period from the procedure performed. Due to the patient’s underlying condition(s), he has a partial dehiscence and is likely to require negative pressure, or perhaps has a jeopardized flap needing hyperbaric oxygen therapy. Is it appropriate to treat him in the outpatient center?
   a. Yes. The physician’s notes need to reflect the complexity of this patient’s condition, including the date of surgery and the complication that has occurred.
   b. The surgeon and the wound care physician can agree on the transfer of postoperative care if the surgeon believes the patient will need more advanced follow-up care than the surgeon can provide in a routine office visit. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center record. The transfer-of-care document should follow the patient to the provider performing the postoperative service and indicate the date of the transfer of care. This should remain on file in the patient’s record. Surgical modifiers 54 and 55 would then be necessary to report on both the surgeon and the wound care clinic physician’s claims communicating the arrangement to the payer, allowing for the appropriate division of the global fee to be made to the wound care physician for providing postoperative care (7-20% of the global package). Keep in mind that any services rendered to the patient while within the global period that are allowed to be paid separately should have a distinct modifier that conveys to the payer why they are not part of the routine postoperative care. Without that qualifying modifier, the services provided at the wound center are at high risk of payment denial.

4) A vascular surgeon who sees patients one day per week in your center wants to see his surgical follow-up patients in the wound center that day because it is convenient for him. (After all, he is going to be there all day, so why not have his patients scheduled to see him while he is there?) Is it appropriate for you to schedule and, more importantly, bill for those patient encounters in your HOPD?
   a. No. These patients do not warrant the additional expense incurred under OPPS simply for the convenience of the doctor to perform routine postoperative care.

5) An elderly patient living with severe edema and recurrent leg ulcers has been followed by you for two years. Her current ulcer has made no progress for four months. She is unwilling to use compression. She is in a nursing home and is brought to you by ambulance twice per month. Your plan of care consists of trying different dressing products. Can you continue to see this patient in the HOPD?
   a. These cases are frustrating. However, under most local coverage determinations (LCDs), if she is not able to fully participate in her care by complying with the treatment plan prescribed, and thus her wound healing fails to progress, the use of the advanced HOPD is not medically reasonable. The hospital OPPS is designed to fund an enhanced level of therapeutic care that is not typically provided in a doctor’s office. Utilizing the provider-based setting (and the Medicare dollars allocated for this program) to care for patients who really should be cared for in other settings (eg, PCP, routine postoperative management, self-care) has led to increasingly restrictive language of many LCDs. The effect is to limit care for patients who do meet LCD criteria. As Medicare struggles to limit inappropriate use of OPPS through regulatory language, clinicians become increasingly burdened with the documentation needed to justify the need for services and to stay current on changing utilization limits. Poor patient selection is driving Office of the Inspector General scrutiny of the OPPS program and has positioned outpatient wound care as a high-risk target for auditors and other recoupment programs. As an industry, it is “time to get our house in order.”
made available to us, the LCDs have become increasingly detailed regarding the requirements necessary for these treatments to be reimbursed under OPPS.

**WOUNDCLINICSELF-ASSESSMENT**

Begin with a careful reading of your current LCDs. Without referencing a particular LCD, here are the types of patient conditions that are specifically **NOT** considered reimbursable by Medicare in the HOPD, based on language from various coverage policies:

Examples of conditions not reimbursed by Medicare in the HOPD by some LCDs:
1. Palliative wound care (patients whose wounds are not expected to heal);
2. Wounds that are no longer showing any evidence of improvement;
3. Patients whose care could be provided by self-care or their primary care doctor; and
4. Patients with acute and uncomplicated wounds.

Wound centers commonly see challenging and complex patients. US Wound Registry (USWR) data demonstrate the average wound center patient lives with eight comorbid diseases and 30% of patients being treated for wounds other than diabetic foot ulcers (DFUs) have diabetes as a complicating factor. These patients are referred to the wound center so that they can undergo thorough evaluation of the factors contributing to healing failure and so a treatment plan can be implemented.

Reimbursement for the treatment we conduct is contingent on addressing all of these underlying conditions. But, do we really do all that we should be doing? When USWR data were reviewed, patients living with venous ulcers left a clinic visit in adequate compression only 17% of the time (the majority were still being told to elevate or were being provided with compression known to be insufficient). Among patients living with DFUs, adequate offloading was documented in only 6% of visits (the majority of DFUs were being “offloaded” with choices like shoe modification). An article published by TWC reported on the results of an initiative run in conjunction with USWR that has been successful in increasing physician compliance with clinical practice guidelines for compression, offloading, vascular screening, and nutritional assessment.

When we are evaluating our services through the lens of the payers, we must remember that from their perspective the purpose of the HOPD is to obtain for the patient an enhanced level of care beyond what’s available in the doctor’s office. Wound centers cannot be merely “dressing-change clinics.” Even though these services may be provided to patients (eg, negative pressure or compression bandaging), they must be provided in the context of a comprehensive plan to address all the factors the patient needs in order to heal. The activities that are being directly supervised by the wound care expert must include the proper diagnosis of the condition(s) that have inhibited normal phases of healing and the creation of a detailed treatment plan for the patient (not just the wound) and the execution of this treatment plan. What happens in some wound centers is a form of “supervised neglect” — a faulty medical treatment in which the treating provider enforces therapies that are either not up to date or ineffective. The patients receive attentive follow-up and frequent medical exams that enforce the illusion of being properly treated when, in reality, ineffective care is being given. It must be remembered that ineffective care is expensive care.

CORRECTINGBADBEHAVIORS

If you’re now concerned that you may not be caring for the most appropriate patients that you should be seeing in your wound center, modifications can be made. Start by reading the LCDs that are applicable to the services you provide. Get a clear understanding of which patients you may currently have in service that do not meet the criteria set forth in these LCDs. Review the treatment plans of your patients to ensure they would be considered medically reasonable. Consult your current active patient list and review all patients who have been in service longer than 90 days to identify those patients who may either need a revised treatment plan or to be discharged from service altogether. This process can be time-consuming and may necessitate meetings with staff members to get everyone on board, but it provides a great opportunity for you to think about what it means to be an advanced wound care center vs. a busy “dressing-change department.” By clarifying your patient-selection process, you will find that you now have time to see the patients who should be there. You will also find that your healing rates and quality reports will be more accurate and useful for operational management. You will find that your staff is less likely to suffer from “burnout” and you can stop lying awake at night wondering if an auditor will recoup a portion of the revenue you have billed. Next, if you bill under OPPS, make sure the wound center has a written scope of practice. This may be the most important policy the clinic can create. Hospitals have consistently failed to understand the importance of this scope of practice and the uniqueness of this billing model. In so doing, you will see that medical necessity is a “practice” that begins with patient selection at the point of referral, not after you have been paid.

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**Reference**