HEALTHTRUST®

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2020: Wound/Ulcer Management Reimbursement Resolutions for the New Decade

A presentation for Healthtrust Members by Kathleen Schaum

Speaker Disclosures

- The presenter has no real or perceived conflicts of interest related to this presentation.

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2020: WOUND/ULCER MANAGEMENT REIMBURSEMENT RESOLUTIONS FOR THE NEW DECADE

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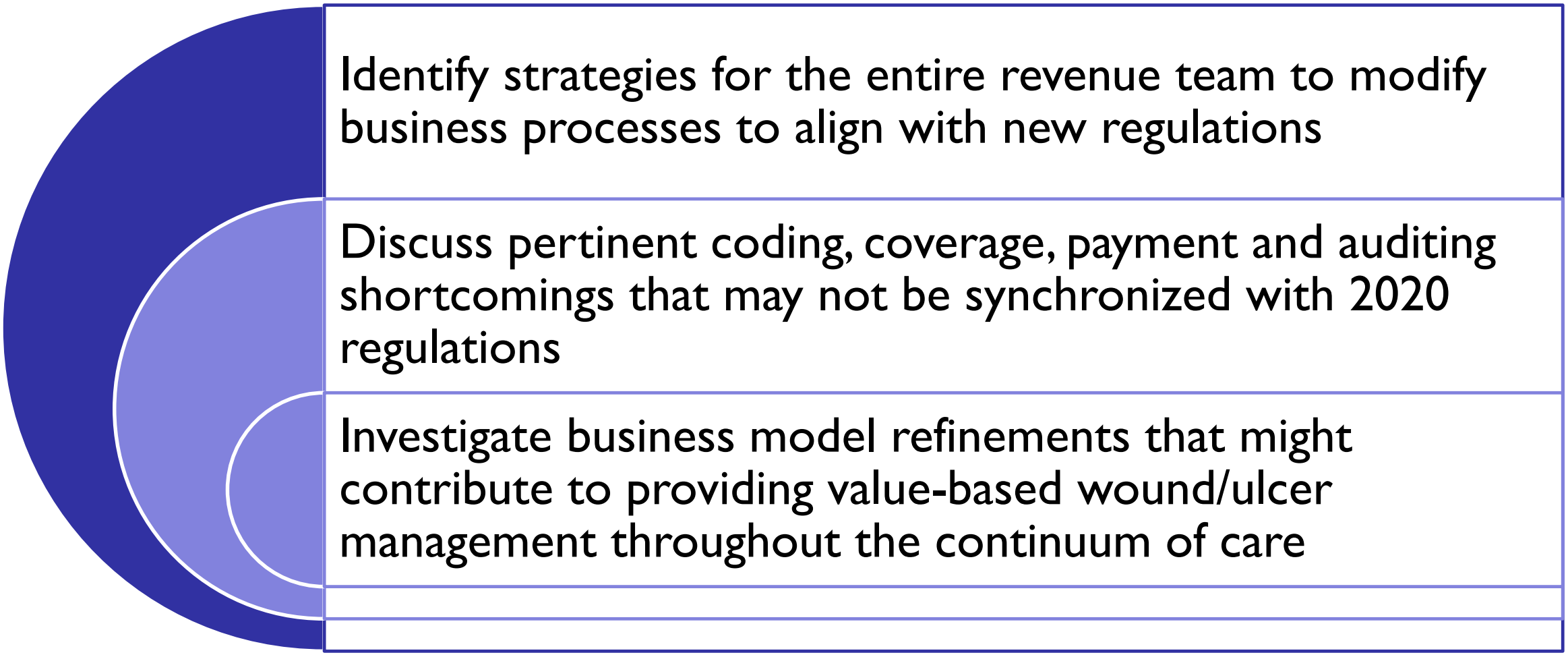
OBJECTIVES


Identify strategies for the entire revenue team to modify business processes to align with new regulations
Discuss pertinent coding, coverage, payment and auditing shortcomings that may not be synchronized with 2020 regulations
Investigate business model refinements that might contribute to providing value-based wound/ulcer management throughout the continuum of care

TRADEMARKS

Current Procedural Terminology 2020. American Medical Association, Chicago, IL 2019

DISCLAIMER

Information on coding, coverage and payment systems is provided as a courtesy, but does not constitute a guarantee or warranty that payment will be provided.

Participants should obtain current regulations and policies pertinent to your practice from the Medicare contractors and the private payers that process your claims.

RESOLVE TO ALIGN YOUR BUSINESS MODEL WITH EXISTING AND NEW REGULATIONS

CHANGE IN SUPERVISION REGULATIONS DID NOT CHANGE PROVIDER-BASED DEPARTMENT(PBD) REGULATIONS

PBD COVERAGE REQUIREMENTS DID NOT CHANGE

- Outpatient therapeutic services must be:
  - Furnished "incident to" a physician's service
  - Furnished under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations and State law
  - Furnished by hospital personnel under the appropriate supervision of a physician or nonphysician practitioner
- During any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, when necessary, to change the treatment regimen

PBD COVERAGE REQUIREMENTS DID NOT CHANGE

- A hospital service or supply would not be considered "incident to" a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment

- For services not furnished directly by a physician or nonphysician practitioner, the CMS expects that the hospital bylaws and policies ensure that the therapeutic services are being supervised in a manner commensurate with their complexity

PBD COVERAGE REQUIREMENTS DID NOT CHANGE

- The supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability and privileges to perform the service or procedure

- The supervisory responsibility is more than the capacity to respond to an emergency and includes the ability to take over performance of a procedure or provide additional orders

PBD COVERAGE REQUIREMENTS DID NOT CHANGE

- The CMS would not expect that the supervisory physician or nonphysician practitioner would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner

Medicare Benefit Policy Manual, Chapter 6, Section 20.5.2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf

OUTPATIENT SERVICE CONDITIONS OF PARTICIPATION (42 CFR §482.54) DID NOT CHANGE

Standard: Personnel. The hospital must—

- Assign one or more individuals to be responsible for outpatient services
- Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services

OUTPATIENT SERVICES CONDITIONS OF PARTICIPATION (42 CFR §482.54) DID NOT CHANGE

Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:

- Is responsible for the care of the patient
- Is licensed in the State where he or she provides care to the patient
- Is acting within his or her scope of practice under State law
- Is authorized in accordance with State law and policies adopted by the medical staff and approved by the governing body, to order the applicable outpatient services. This applies to:
  1. All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services
  2. All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients

ORDER REQUIREMENTS FOR PBD SERVICES DID NOT CHANGE

The following is required for a PBD service to be covered by Medicare:

- Documentation that supports medical necessity of the PBD service (e.g. physician's visit note, progress note, etc.)
- A signed and dated physician's order for the PBD service; no "standing orders"
- Documentation showing that the service was provided

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforOrderingHospitalOutpatientServices-ICN909405.pdf

SIGNATURE REQUIREMENTS FOR PBD SERVICES DID NOT CHANGE

Physician/Non-Physician (NPP) Signature Requirements:

- The ordering practitioner must authenticate the services that are provided or ordered
- Signatures must comply with Medicare's signature requirements

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

EFFECTIVE JANUARY 1, 2020, ONLY THE REQUIRED LEVEL OF SUPERVISION FOR MEDICARE PAYMENT CHANGED

In order to receive Medicare payment for outpatient therapeutic services incident to a physician's service, the CMS changed the minimum required level of supervision from "direct supervision" to "general supervision"

- Applies to all outpatient therapeutic services for all hospitals, including rural hospitals and critical access hospitals
- Providers and physicians have the flexibility to require a higher level of supervision for particular services as they deem necessary
- **Reminder: Wound/ulcer management professionals can only provide procedures allowed by their State Practice Act and by the hospital by-laws and for which they are credentialed**

IMPORTANT FACTS TO CONSIDER WHEN WRITING THE PBD SUPERVISION POLICIES AND PROCEDURES

The supervising physicians are still subject to Medicare Part B's Conditions of Participation

The supervising physicians cannot let the actual care standards lapse just because PBD's supervision requirements have changed

The supervising physicians are still required to follow State laws regarding patient care

The PBD supervision payment change does not reduce the physician's liability if standard of care is breached. A change of PBD supervision requirement is not a defense if a malpractice suit is brought against a provider

Providers have the flexibility to establish what they believe is the appropriate level of physician supervision in PBDs

RESOLVE TO IMPROVE CODING SHORTCOMINGS

FIX THEM, IF THEY APPLY TO YOUR BUSINESS!

REVIEW PROCEDURE CODE & PRODUCT CODE DEFINITIONS

Watch for procedure code units

- Per 20 sq. cm.
  - Example: 11042
- Per 25 sq. cm.
  - Example: 15271
- Per day
  - Example: 97610
- Per 30 minutes
  - Example: G0277
- Per session
  - Example: 99183

Watch for product code units

- Per each
  - Example: A6021
- Per sq. cm.
  - Example: Q4101

KEEP CHARGE DESCRIPTION MASTER (CDM) AND CHARGING SYSTEM UPDATED

- Delete outdated codes
- Add new codes with appropriate units
- Revise codes with description changes

EXERCISE CAUTION WHEN REPORTING E/M (CLINIC VISIT) CODES WITH MODIFIER -25 WHEN PERFORMING MINOR PROCEDURES

Myths

- Report an E/M (clinic visit) code with modifier -25 for every patient visit, even when a minor procedure is performed
- Report an E/M (clinic visit) code with modifier -25 for all **new** patient visits, even when a minor procedure is performed

Truths

- All minor procedures include E/M (clinic visit) services related to the decision to perform the procedures
- Only report an E/M (clinic visit) code with modifier -25 when a significant and separately identifiable E/M (clinic visit) service is performed on the same date as a procedure or other therapeutic service
- The rule for using an E/M (clinic visit) code with modifier -25 is identical for new and established patient visits

RESOLVE TO IMPROVE COVERAGE SHORTCOMINGS

FIX THEM, IF THEY APPLY TO YOUR BUSINESS!

REVIEW COVERAGE POLICIES ON A MONTHLY BASIS

Assign someone to review, read and share coverage changes on a monthly basis

Treat coverage policies as the professionals' "playbook"

Incorporate coverage policies into clinical practice guidelines

Incorporate documentation guidelines, specified in coverage policies, into documentation templates

ENSURE MEDICARE WILL COVER SUPPLIES AND/OR EQUIPMENT NEEDED BY YOUR PATIENTS FOR THEIR USE AT HOME

- Document the medical necessity for the supplies and/or equipment
- Follow the new Standard Written Order (SWO) requirements – effective January 1, 2020
  - Beneficiary's name or Medicare Beneficiary Identifier (MBI)
  - Order date
  - General description of the item
  - Quantity to be dispensed, if applicable
  - Treating practitioner name or National Provider Identifier (NPI)
  - Treating practitioner's signature
- "PRN" orders will not be covered or paid by Medicare
- Medical record must contain all elements of the SWO: prescriptions are still not considered part of the medical record

RESOLVE TO IMPROVE PAYMENT SHORTCOMINGS

FIX THEM, IF THEY APPLY TO YOUR BUSINESS!

READ PERTINENT CHAPTERS OF *NATIONAL CORRECT CODING INITIATIVE (NCCI) CODING POLICY MANUAL FOR MEDICARE SERVICES*

- Updated every year on January 1
- Explains the rationale for the NCCI procedure-to-procedure edits

Pertinent Chapters:

Introduction

Table of Contents

Chapters that discuss CPT® code for the services and procedures performed by your wound/ulcer management team

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

REVIEW NCCI PROCEDURE-TO-PROCEDURE (PTP) EDITS

HTTPS://WWW.CMS.GOV/MEDICARE/CODING/NATIONALCORRECTCODINITED/NCCI-CODING-EDITS

- Updated quarterly: January 1, April 1, July 1 and October 1
- Prevents improper payment when incorrect code combinations are reported for the same patient encounter

Learn how to sort the NCCI PTP edits by reading:

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

ICN 901346 January 2019

USE SPECIFIC "DISTINCT PROCEDURE" MODIFIERS

59 – "***Distinct Procedural Service:*** *Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day"*

XE – "***Separate Encounter:*** *A service that is distinct because it occurred during a separate encounter". This modifier shall only be used to describe separate encounters on the same date of service"*

XS – "***Separate Structure:*** *A service that is distinct because it was performed on a separate organ/structure"*

XP – "***Separate Practitioner:*** *A service that is distinct because it was performed by a different practitioner"*

XU – "***Unusual Non-Overlapping Service:*** *The use of a service that is distinct because it does not overlap usual components of the main service"*

RESOLVE TO IMPROVE AUDITING SHORTCOMINGS

FIX THEM, IF THEY APPLY TO YOUR BUSINESS!

THREE PILLARS OF A SUCCESSFUL AUDIT PROGRAM

1. Conduct Internal Audits on Pertinent Topics such as:

- Coding rules
- Payment system regulations
- Claim denial reasons
- Medical record documentation requirements
- Audit topics of your Medicare Administrative Contractor, all other contractors who audit Medicare providers and the Office of Inspector General Work Plan

THREE PILLARS OF A SUCCESSFUL AUDIT PROGRAM

2. Respond to all Additional Documentation Requests (ADRs)

- Identify who is conducting the audit
- Determine the reason for the audit and list the requested documentation components outlined in the ADR
- Confirm how to submit a complete and timely response
- Assemble the documentation packet to include:
  - Original ADR
  - Your specific point of contact
  - Requested documentation in chronological order
  - Number each page in the packet and make a copy of the entire packet
- Submit the packet at least two weeks before the deadline

THREE PILLARS OF A SUCCESSFUL AUDIT PROGRAMS

3. Learn From Every Audit

Example:

- Participate in education programs offered after each round of Targeted Probe and Educate (TPE) audits
- Select day and time to allow members of the clinical team and revenue cycle team to participate in the TPE audit findings and recommendations
- After the education program, meet and decide the processes that must be refined
- Each team member should do his or her part to implement the new processes immediately so the business can pass the next round of the TPE audit

RESOLVE TO INVESTIGATE BUSINESS MODEL REFINEMENTS THAT MIGHT CONTRIBUTE TO PROVIDING VALUE-BASED WOUND/ULCER MANAGEMENT THROUGHOUT THE CONTINUUM OF CARE

LOOK FOR NEW OPPORTUNITIES!

IT MAY BE TOO LATE IF YOU WAIT FOR OPPORTUNITIES TO COME TO YOU!

DETERMINE IF NEW SNF MEDICARE PAYMENT SYSTEM OFFERS OPPORTUNITIES TO YOUR BUSINESS

Effective October 1, 2019

SNFs converted from the Resource Utilization Groups (RUGs) Medicare payment system to the Patient-Driven Payment Model (PDPM)

- PDPM eliminates the incentive to provide therapy and focuses on clinical complexity
- PDPM uses patient characteristics to assign patients into case-mix payment groups
- PDPM pays SNFs a higher rate for patients with wounds/ulcers

DETERMINE IF NEW HHA MEDICARE PAYMENT SYSTEM OFFERS OPPORTUNITIES TO YOUR BUSINESS

Effective January 1, 2020

HHAs converted from Home Health Resource Groups (HHRGs) to Patient-Driven Groupings Model (PDGM)

- PDGM eliminates therapy service thresholds
- PDGM pays HHAs a higher rate for patients with wounds/ulcers

CONSIDER OFFERING NON-FACE-TO-FACE ESTABLISHED PATIENT SERVICES

G2010 *Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours*	Follow up by physician/qualified healthcare professional (QHP) may be via HIPAA compliant phone, audio/video, secure text messaging, or email.
G2012 *Brief communication technology-based service initiated by an established patient, e.g., virtual check-in*	Virtual check-in must be a real-time, two-way audio and/or video conversation. It cannot be a voice message.

CONSIDER EXPANDING PHYSICIAN/QHP BUSINESS WITH PATIENT-INITIATED E/M SERVICES

3 new codes effective January 1, 2020

- 99421 *Online digital E/M services, established patient, for up to 7 days of cumulative time; 5-10 minutes*
- 99422 *11-20 minutes*
- 99423 *21 or more minutes*

Established patient sends message about her/his problem via a patient portal, secure email, or other HIPAA-compliant digital communication

Physician/QHP assesses patient data that is significant to the reported problem and provides the patient with a care plan

Physician/QHP documents time spent over 7 days

CONSIDER EXPANDING NONPHYSICIAN HEALTHCARE PROFESSIONAL'S BUSINESS WITH PATIENT-INITIATED E/M SERVICES

3 new codes effective January 1, 2020

- 98970 *Qualified nonphysician healthcare professional online digital E/M services, established patient, for up to 7 days of cumulative time; 5-10 minutes*
- 98971 *11-20 minutes*
- 98972 *21 or more minutes*

CAUTION: The CMS will not accept the new codes because they include E/M services. The CMS created other codes (G2061-G2063) that do not mention E/M services.

CONSIDER EXPANDING NONPHYSICIAN HEALTHCARE PROFESSIONAL'S BUSINESS WITH PATIENT-INITIATED E/M SERVICES

3 new codes effective January 1, 2020

G2061 Qualified nonphysician healthcare professional *online assessment, established patient, for up to 7 days of cumulative time; 5-10 minutes*

G2062 *11-20 minutes*

G2063 *21 or more minutes*

- **Established patient sends message about her/his problem via a patient portal, secure email or other HIPAA-compliant digital communication**
- **Physical therapists, occupational therapists, dietitians and social workers assess patient data that is significant to the reported problem and provides the patient with a care plan**
- **Nonphysician healthcare professional documents time spent over 7 days**

CONSIDER EXPANDING PHYSICIAN/QHP BUSINESS BY OFFERING INTERPROFESSIONAL TECHNOLOGY BASED CONSULTATIONS

Telephone/internet/electronic health record assessment and management

- Requesting/treating provider can report 99452 if he/she spends a minimum of 16 minutes preparing for the referral and/or communicating with the consulting provider and the medical record documentation includes written/verbal request for consultation and reason for the request
- Consulting provider can bill 99451 when **less than 50% of the consultative time is dedicated to data review or analysis** and includes a **written report**
- Consulting provider can bill 99446-99449 when greater than 50% of the consultative time is dedicated to data review or analysis and includes a **verbal and written report**

THANK YOU FOR INVITING ME TO SHARE REIMBURSEMENT RESOLUTIONS THAT YOU SHOULD CONSIDER MAKING IN 2020 . . .

~KATHLEEN SCHAUM

HEALTHTRUST®

Thank you!

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