

Advocacy & Policy

Current Events/Articles

1 Announcement of new procedure code for multilayer compression bandages:

No longer is there confusion about whether high compression bandage systems fall under the procedural code for Unna boots or surgical dressings. The AMA has created a new Category I CPT code that describes the application of the numerous multi-layer compression bandages available on the market today. CPT code 29581 – “Application of multi-layer venous wound compression system, below the knee.” becomes effective on January 1, 2010. In the final rule CPT code 29581 has been assigned to the APC payment group 0058 which has a 2010 payment rate of \$71.03 and a status indicator of S. The S indicator is important because it means that the service is significant and will not be discounted for multiples.

2 CMS eliminates consultation codes

Effective January 1, 2010, CMS will eliminate outpatient and inpatient consultation codes. This ruling will impact all medical practices, including the physicians who practice in your outpatient wound care clinic. Many physicians currently code many outpatient encounters as consultations. Generally, consultation codes pay between 29 and 55 percent more than new office patient codes (99201-99205).

On the inpatient side, admission codes (99221-99223) will be used in lieu of consultation codes. The "true" admitting physician will use a modifier along with their admit code, while all consulting physicians will use the admit code without the admit modifier.

3 CMS clarifies direct supervision in outpatient clinics:

The **2009** Outpatient Prospective Payment System Final Rule greatly affected wound clinics that were operating without any direct physician supervision. Those which were directly supervised by non physician practitioners (Nurse Practitioners, Physicians Assistants, etc) or staffed by wound care nurses without any direct supervision could not bill a facility fee. Doing so would result in a fraudulent claim. A physician must be present in the 'footprint' of the wound care department. This does not mean available on the hospital campus, in the doctors' lounge, in surgery or in the emergency room. If a non-professional physician provider provides the service, they can still bill for their professional fee, but the hospital can not bill the facility fee.

This 2009 clarification to the 2000 rule was not well received by hospitals. **CMS has listened and has made the following modifications in the 2010 Final Rule:**

a. Physicians Orders

"Services and supplies must be furnished on a physician's order and delivered under physician/non physician supervision. Each occasion of a

service does not need to also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient. However, during the course of treatment rendered by auxiliary personnel, the physician/non physician practitioner must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen."

Interpretation: *Non-physician providers (defined as nurse practitioners, clinical nurse specialists and physician assistants) may also provide direct supervision. BSN-prepared wound nurses may NOT provide outpatient wound care services without direct supervision. The physician should be documenting a history and physical and ongoing progress notes to validate their supervision and management.*

b. On-Campus Supervision

"For services provided in the hospital or on-campus of the hospital, the *supervisory physician or non physician practitioner* must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure."

"Immediately available" means that person cannot be performing another procedure or service that he or she could not immediately interrupt.

"The physician or non physician practitioner must be prepared to step in and perform the service, not just to respond to an emergency. This includes the ability to take over the performance of a procedure and, as appropriate, to change a procedure or the course of treatment being provided to a particular patient. The physician or non physician practitioner is not required to be in the room where the procedure is performed."

"For 2010, non physician practitioners (clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives) may directly supervise all hospital outpatient therapeutic services that they may perform themselves within their State law and scope of practice and hospital-granted privileges, provided that they meet all additional requirements, including any collaboration or supervision requirements, as specified in the regulations at §§410.74 through 410.77."

Interpretation: The supervising physician or non-physician provider must be available in the clinic, and not down the hall in the emergency room or surgery suite. They must be immediately available to "step in" and must be able to perform the procedure themselves if indicated. (ie: VAC dressing change, sharp debridement, application of compression wraps.)

For the full text of the Final Rule, go to:

http://federalregister.gov/OFRUpload/OFRRData/2009-26499_PI.pdf.

4 Medicare Provider Enrollment, Chain and Ownership System (PECOS) Update

Mary Teasdale Wolff, MSN, RN, CWOCN, Lee Ann Krapfl, BSN, RN, CWOCN

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing a change in the reimbursement process for durable medical equipment, orthotics, prosthetics and supplies. This process change is scheduled to go into effect on January 4, 2010. Effective on this date, all prescribing providers must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). If the ordering provider is not on the PECOS list, or is of a specialty ineligible to order certain services, then the Medicare B claim will be denied. With the deadline rapidly approaching, this will no doubt cause some confusion for providers, suppliers and patients.

Why is this change being implemented?

Answer: Billions of Medicare dollars are paid each year for fraudulent claims. In an effort to reduce fraudulent billing, all claims sent by a supplier must include the name of the ordering/referring provider before the claim will be paid. As the number of physician and non-physician providers grew each year, the Medicare provider data base was not big enough to capture this growth. The PECOS list was started in 2003 in an attempt to capture the growing number of new providers. Streamlining claims processing using a single provider data base will improve the ability to audit for fraud. But the current PECOS list will not have the name of any approved Medicare provider practicing before 2003, unless that provider updated their personal information in the past 6 years.

What does this mean for physicians and non-physician providers (nurse practitioners, clinical nurse specialists and physician assistants?)

Answer: All providers who order durable medical equipment, prosthetics, orthotics and supplies will need to make sure their information is up-to-date on the PECOS list.

What does this mean for suppliers?

Answer: Although these are private businesses, they must follow the Medicare regulations if they hope to get paid for items they supply to Medicare beneficiaries. If a claim is submitted and the ordering provider cannot be found on the PECOS list, the claim is currently being paid. But a message is being sent with the payment letting the supplier know that the provider cannot be found on the PECOS list. After January 4, 2010, those same claims will be denied.

What does this mean for patients?

Answer: If the supplier does not accept assignment, they will ask the patient to pay for the equipment or supplies and then submit the claim. The patient receives their reimbursement directly from Medicare. If the ordering provider is not on the PECOS list, the patient will not be reimbursed.

How does someone find out if a provider is on the PECOS list?

Answer: Internet-based PECOS will allow physicians, non-physician practitioners, and provider and supplier organizations the option of enrolling, making a change in their Medicare enrollment information, viewing Medicare enrollment information, or tracking the status of their Medicare enrollment applications throughout the Internet submission process.

The Internet address for PECOS is:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp. To access the site, the provider will need to register with a NPPES user ID and password.

What does this mean for me?

Answer: If you have prescriptive authority as a nurse practitioner or certified clinical nurse specialist, check with your facility or organization to see if you are listed on PECOS. Many facilities and organizations already have processes in place to get their providers' information updated on this list.

If you receive documents to revalidate your Medicare eligibility, sign and return them as soon as possible.

The Medicare contractors will have to review and approve each application before any provider is listed on PECOS. This entire process can take several weeks. There will obviously be many providers working to update their information, so it is best not to wait until the last minute.

If you are a BSN-prepared WOC nurse, you can take a deep breath because this does not apply to your license. But as a patient advocate, you may experience confusion and frustration in obtaining supplies and equipment for patients in the short term.

Still unanswered questions?

There is information and consequences that are yet unknown.

--What happens if a provider completes the revalidation paperwork, but the approval process is not completed by January 4, 2010?

--If reimbursement is in question, will the retailer or supplier refuse to provide the necessary equipment and supplies to patients, fearing a possible claim denial?

--How heavy handed will CMS be with reimbursement denials after the January 4 deadline? Can the decision be appealed? Or resubmitted? Will the January deadline be extended?

Answer: The WOCN Public Policy Committee continues to monitor and review information regarding this issue. We will continue to update you as information becomes available. The following links are available for more detailed information.

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf>

<http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6417.pdf>

<http://www.cms.hhs.gov/Transmittals/downloads/R572OTN.pdf>

For specific questions, feel free to contact Mary Teasdale by e-mail at: mom_teadale@yahoo.com.