Connecting patients with a restorative nursing program

To start a restorative nursing program, first discuss its benefits with the patient and ensure he or she is willing to participate. Next, work with therapists to identify the appropriate exercises that restorative nurses and nursing aides will perform with the patient. Physician clearance is recommended.

Remember that the program can be enhanced with interactive activities such as obstacle courses, video games, gardening, dance classes, tai chi, and bowling to keep your patients mobile.

Be proactive

The more active and mobile your patients are—and the earlier they begin activity—the less likely they will develop a pressure ulcer. You might want to have a policy in your care setting that automatically triggers a restorative nursing program for residents who score poorly for mobility and/or activity on the Braden Scale. The program may be just what the patient needs to protect him or her from harm. ■

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Top 10 outpatient reimbursement questions

By Kathleen D. Schaum, MS

At the 2015 Wild on Wounds conference, the interactive workshop "Are You Ready for an Outpatient Reimbursement Challenge?" featured a lively discussion among participants about 25 real-life reimbursement scenarios. Here are the top 10 questions the attendees asked, with the answers I provided.

Q Why is it necessary for qualified healthcare professionals (QHPs) such as physicians, podiatrists, nurse practitioners, physician assistants, and clinical nurse specialists to identify the place of service where they provide wound care services and to correctly state the place of service on their claim forms?

A In any given day, QHPs often perform wound care services for patients in various sites of care. For example, a physician may spend the first 4 hours of the day in the hospital-based outpatient wound care department (place of service

22), then see patients for 2 hours in the hospital (place of service 21), and finally see patients for 2 more hours in his or her private office (place of service 11). Because the Medicare Physician Fee Schedule pays more for services provided in a QHP's office than in facilities, the QHP must establish a process for informing billers exactly where each patient encounter occurred. Otherwise the billers may assume that all the encounters occurred in the QHP's office and will overbill the Medicare program.

Q Why is it important to know whether the outpatient wound clinic is a hospital-based outpatient wound care department (HOPD) or a QHP office called a wound clinic?

A When patients are seen by a QHP in an HOPD, the patients and Medicare receive two bills: one from the HOPD and one from the QHP. When patients are seen by a QHP in his or her office, the patients and Medicare only receive one bill. Patients should be informed whether they should expect one or two bills.

Q Why can't wound care and ostomy professionals working in HOPDs make decisions to change orders and send them to a QHP for signature after the work is performed?

A Emergency departments (EDs) and HOPDs are paid by the same Medicare payment system. Just as EDs require direct supervision, so do HOPDs. Therefore, a QHP must go to the HOPD, assess the patient's condition, and change the orders if the QHP deems the change is necessary. Then the wound care and ostomy professional may proceed with the work. It's important to remember that the Centers for Medicare & Medicaid Services (CMS) has reiterated that direct supervision cannot be provided via the phone.

Q When will CMS release National Coverage Determinations (NCDs) and when will the Medicare Administrative Contractors (MACs) who process claims release Local Coverage Determinations (LCDs) with ICD-10 codes?

A Both CMS and the MACs already released "future effective" NCDs and LCDs in the spring of 2015. The ICD-10 codes have been implemented, so these "future effective" NCDs and LCDs have been converted to "active" NCDs and LCDs. All wound care professionals should locate these updated documents on either the CMS Medicare Coverage Database or their MAC's website.

Q Why should all wound care professionals read the NCDs and LCDs that pertain to the wound care work they perform?

A NCDs and LCDs provide Medicare coverage rules that specify the following:

- coverage indications, limitations, and/or medical necessity
- covered/non-covered product codes, procedure codes, and modifiers
- covered diagnosis codes
- utilization guidelines
- documentation guidelines.

Wound care professionals must know these coverage rules. If a Medicare patient's medical condition aligns with the coverage rules, the service/product/procedure has a good chance of Medicare payment. If not, the wound care professional

should explain the coverage situation to the Medicare beneficiary and give the beneficiary the opportunity to receive and personally pay for the necessary care. That is achieved by the wound care professional providing the Medicare beneficiary with an Advance Beneficiary Notice of Noncoverage (ABN) and by the beneficiary signing the notice and agreeing to pay for the care.

Q How often should wound care professionals look for updates to LCDs?

A MACs may update LCDs as often as they deem necessary. Some LCDs were updated 5 or 6 times in 2014. Therefore, wound care professionals should assign someone to review LCDs on a monthly basis. When LCDs are revised, all wound care professionals should read them carefully.

Q Is it true that if an LCD is not written about a particular service, procedure, or product, Medicare does not cover it?

A No. If a MAC has not released an LCD, it means the MAC has not found a reason to control the utilization of the particular service, procedure, or product. In this case, coverage will be based on medical necessity as proven by the patient's diagnosis and the documentation in the medical record.

Q How can I find out if Medicare will pay for two different procedures performed during the same encounter?

A Simply read the National Correct Coding Initiative (NCCI) Edit Manual that is effective each January and refer to the NCCI electronic files that are updated on a quarterly basis in January, April, July, and October.

Q Is it true that CMS limits the number of units that may be reported on a claim for some procedures?

A Yes, that is partially true. CMS publishes a list of Medically Unlikely Edits (MUEs) that identifies the maximum number of units that may be submitted per date of service or per claim. PLEASE NOTE: CMS does not publish all of the edits for number of units allowed – some are known only to CMS and the MACs that process the claims. Nevertheless, wound care professionals can easily locate the published MUEs on the NCCI web page.

Q The coders insist that the number of units for the application of cellular and/or tissue-based products for wounds (CTPs) [outdated term "skin substitute"] and the number of units for the actual CTP should match exactly. Is that true?

A No. The number of units reported for the application of the CTPs should follow the description of the application code, which will either be for 25 or 100 sq cm increments of wound surface area. The number of units reported for the actual CTP depends on the number of sq cm that were opened for that application. For example: If 21 sq cm of a particular "low-cost" CTP were opened for an 18 sq cm wound on the leg, the HOPD claim to Medicare would be:

C5271	1 unit
QXXXX	21 units

BONUS Q:
I am a QHP and work in an HOPD. When I debride epidermis and/or dermis, I want to use the code 11042. My coders say that I should use the code 97597. I believe that is a code for physical therapists and not a code for QHPs. In addition, I do not like the Medicare allowable for 97597. Am I correct to use 11042?

BONUS Q:
No. The QHP should congratulate his or her coders because they are doing their best to provide correct coding rules. The 2015 CPT®* manual clearly describes 97597 as the code to use when only epidermis and/or dermis are debrided. It is true that CMS designated 97597 as a "sometimes therapy" code. That simply means that therapists who perform 97597 are required to attach a therapy modifier to the code on the claim from. If QHPs perform 97597, they simply bill the code on the claim form; no modifier is required. It's important to remember that wound care professionals should not select codes to report based on the reimbursement rates they like best.

If you wish to learn more about these and other reimbursement topics, you and your revenue cycle team may want to attend one of the twelve 2015 Wound Clinic Business seminars that will be offered in 2016; see **www.woundclinicbusiness.com**.

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The power of the positive

The authors put positivity in action to build better teams and improve organizational performance.

By Paige Roberts, MBA, BSN, RN, PCCN, and Kaitlin Strauss, BSN, RN, PCCN

Being positive in a negative situation is not naïve. It's leadership.

— Ralph S. Marston, Jr., author and publisher of The Daily Motivator website

Clinicians may encounter many challenges and stressors in the workplace—long hours, rotating shifts, inadequate staffing, poor teamwork, and pressure to achieve higher performance levels in an emotionally and physically demanding field.

But hope exists. Positive psychology uses scientific understanding and interventions to help people achieve a more satisfactory life. Positive psychologists have shown that building positive emotions can change the way we approach and view our environment, helping us become healthier, happier, and more resilient and helping employees and teams become more productive and engaged.

Research on positive emotion over the last 15 years focuses on using positivity to build resources and resilience. A leading researcher in this area is Barbara Fredrickson, who developed the "broad-