



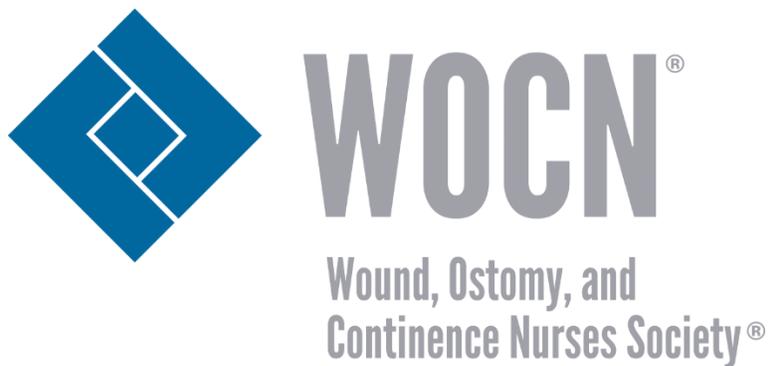
WOCN[®] Wound, Ostomy, and
Contenance Nurses Society[®]

REIMBURSEMENT OPPORTUNITIES FOR WOC NURSING SERVICES: MEDICARE PAYMENT FOR ADVANCED PRACTICE NURSE SERVICES:

A FACT SHEET



Reimbursement Opportunities for WOC Nursing Services: Medicare Payment for Advanced Practice Nurse Services: A Fact Sheet



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Reimbursement Opportunities for WOC Nursing Services: Medicare Payment for Advanced Practice Registered Nurse Services: A Fact Sheet

Originated By:

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Reimbursement Opportunities for WOC Nursing Services: Medicare Payment for Advanced Practice Registered Nurse Services: A Fact Sheet

Purpose:

To provide the Wound Ostomy Continence (WOC) Advanced Practice Registered Nurse (APRN) with information on the opportunities and challenges to obtain Medicare reimbursement for professional services.

Background:

Medical practices, hospitals, skilled nursing and rehabilitation facilities, long-term care facilities, clinics, and home health agencies have found that Advanced Practice Registered Nurse services are often key to providing high-quality and cost-effective care. This is especially true for the patient who requires the services of a WOC APRN.

Medicare allows for direct reimbursement to WOC APRNs who are nurse practitioners (NPs) and clinical nurse specialists (CNSs) providing Part B services often rendered by a physician. These services are not limited by site or geographic location. WOC APRNs may see all new and established patients without restriction. A physician is not required to be "on site". According to Medicare statute, authorized services and the physician relationship for APRN reimbursement is defined by the individual State's Nurse Practice Act and the Rules and Regulations for APRNs. Medicare program qualifications require that the APRN be certified by a national certifying body with established standards.

Private insurance companies often follow the rules determined by Medicare for reimbursement. However, WOC APRNs should consult each payer individually for billing instructions and reimbursement policies. Medicaid regulations for payment will vary by individual State.

Wide variance in State laws and significant differences in payment policies for APRN services make the quest for reimbursement challenging. This fact sheet will provide the basic Medicare rules for coverage, billing, and payment. WOC APRNs who intend to bill for services should consult the CMS Manual System, review benefit policy and claims filing instructions, and work with coders and billing personnel to ensure accurate reporting of services.^{1,2,3}

Medicare Qualifications for the WOC APRN

To furnish Medicare covered services and be eligible for payment, a WOC APRN must meet the following conditions:

❖ Nurse Practitioner:

- Is a registered nurse authorized to practice as a NP by the State in which services are furnished and certified by a national recognized body that has established standards for nurse practitioners; or
- Is a registered professional nurse authorized to practice as a NP by the State in which services are furnished by December 31, 2000.
- Possesses a master's degree in nursing if applied the first time for a Medicare billing number on or after January 1, 2003.

❖ **Clinical Nurse Specialist:**

- Is a registered nurse licensed to practice by the State in which services are furnished and authorized to furnish clinical nurse specialist services in accordance with State law.
- Has a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- Is certified as a clinical nurse specialist by a national recognized body that has established standards.

Medicare recognizes the following national certifying bodies:

- AACN Certification Corporation;
- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Board of Certification of Hospice and Palliative Nurses;
- National Certification Corporation for Obstetrics, Gynecologic, and Neonatal Nursing Specialties;
- Oncology Nurses Certification Corporation;
- Pediatric Nursing Certification Board.

Medicare Coverage Criteria for Services

❖ Services must be *medically reasonable and necessary* as follows:

- Required for the diagnosis or treatment of the beneficiary's medical condition;
- Furnished for the diagnosis, direct care and treatment of the beneficiary's medical condition;
- Meet the standard of good medical practice; and
- Not mainly for the convenience of the beneficiary, provider, or supplier.

❖ *Requirements for coverage* of services are as follows:

- The APRN works in collaboration with one or more physicians to deliver health care services within the scope of professional expertise;
- Medical direction and appropriate supervision is provided as required by State law in which the services are furnished;
- APRN services are the type considered to be those furnished by a medical doctor or doctor of osteopathy;
- Services are not otherwise precluded due to statutory exclusion; i.e., those not included in the law or specifically identified as non-covered; and
- The APRN is legally authorized and qualified to furnish the services in the State where provided.

Medicare Enrollment Requirement

WOC APRNs must enroll in the Medicare program to be eligible to receive payment for covered services. Information on the enrollment process is available at:

<http://www.cms.gov/MedicareProviderSupEnroll/>. WOC APRNs can apply for enrollment in Medicare or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (Form CMS 8551).

For WOC APRNs who are part of a clinic or group practice, Form CMS-855B is used to initiate the enrollment process; CMS-855R must also be completed as a separate application to reassign benefits to each organization. If a WOC APRN terminates association with an organization, the same form is used to submit that change. The various Medicare Administrative Contractors (MACs) offer a *Provider Enrollment Application Assistance Tool* on their websites removing the guesswork in determining which enrollment form to use.

Billing Medicare for Services: Overview

Claims for services are submitted to the *Medicare Administrative Contractor (MAC)* assigned to the geographic region where the service is provided. WOC APRNs may direct bill under their *national provider identifier (NPI)* and receive payment for services approved by Medicare. Alternatively, WOC APRNs may reassign payment to their employer, in which case the employer's NPI is used for billing.

The NPI is a unique ten-digit identifier assigned by the National Plan and Provider Enumeration System to qualified practitioners (e.g., WOC APRNs) who bill Medicare and all other insurers for services. Application for the NPI is available at: <https://nppes.cms.hhs.gov>. *Applying for the NPI is a process separate from Medicare enrollment.*

WOC APRNs can see patients in any setting without the presence of a physician and bill for the level of care provided, time spent with the patient, diagnosis, preventative medicine, certain procedures, and patient counseling. WOC APRNs must document and report services according to the CMS Documentation Guidelines⁴ available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>.

Billing is a complicated process, requiring education and resources to maximize reimbursement and avoid inappropriate practices. Consequently, WOC APRNs should become knowledgeable about billing regulations and work with their appropriate billing department. It is advantageous to have outside reviewers audit billing practices. Documentation is crucial to support the level of service coded and submitted for reimbursement and, depending on the service billed, may require the following: systems reviewed, examination performed, diagnoses made, treatment provided, and recommended follow-up care.

In addition to independent billing, WOC APRNs may also bill Medicare for “incident to” services. For details on this Medicare policy, including definitions, sites of service, billing, and other important details, refer to the WOCN Society fact sheet entitled: Reimbursement Opportunities for WOC Nursing Services: Medicare Part B “Incident To” Services Policy: A Fact Sheet (2018).

Medicare Payment for Services: Overview

Medicare payment for approved WOC APRN services is made according to the published Physician Fee Schedule (PFS).⁵ Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for work, practice expense, and malpractice.

WOC APRN services billed independently are paid at 85% of the allowed PFS amount. For direct payment under Medicare, WOC APRNs are required to accept *assignment*. This means that they must accept the amount allowed by Medicare as payment in full. WOC APRNs cannot bill the beneficiary an additional amount or collect other fees *except* unmet deductibles and coinsurance amounts as defined under Medicare Part B. WOC APRNs may not receive separate payment when a facility or other provider charge or payment is made for the same professional services. This includes hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, ambulatory surgery centers, community mental health centers, rural health centers, or federally qualified health centers.

WOC APRNs are authorized to receive Medicare reimbursement for serving as “attending physicians” in hospice and home health care. While this does not allow them to order/authorize hospice or home health care, it does authorize them to recertify patient eligibility for hospice care. For beneficiaries to obtain home health care, a face-to-face encounter with an eligible provider must occur within 90 days of the start of service. WOC APRNs may conduct that encounter, but a physician must document its occurrence.

Inpatient Payment for Services

WOC APRN services allowed by Medicare and provided in the inpatient setting may be reimbursed through Medicare Part B as described above. The hospital can bill for these services under the Part B benefit if the WOC APRN’s salary and benefits are not reimbursed under; i.e., are unbundled from, the hospital’s cost report. For WOC APRNs who are self-employed or employed by a physician, physician group or medical school, covered services are reimbursable if they are not a duplicate charge of a service billed by another provider.

Federal regulations define what services may be reimbursed in the inpatient setting as: diagnosis, therapy, surgery, consultation, and care plan oversight. Services are coded and categorized by the type of visit (e.g., new, consultation, established). These are then further stratified based on history, examination, and medical decision making. Medicare principles that guide billing for WOC APRN inpatient services are as follows:

1. The service is one normally provided by a physician.
2. The service is not just one part of a bundled service.
3. The service is within the APRN scope of practice under State law.
4. The service is medically necessary.
5. The APRN meets Medicare credentialing requirements.
6. Documentation of the service provided conforms to Medicare requirements for the procedure code billed.
7. Generally, APRN services should be billed under the APRN’s NPI.
8. It is permissible to bill visits “shared” with physicians, under certain conditions.

9. Medicare allows payment for **one charge per day**, per patient, per specialty, for Evaluation and Management (E/M) billing.
10. A hospital may not bill Medicare Part B for APRN services if the hospital receives any reimbursement for the APRN's salary under the hospital cost report. The APRN's salary and benefits must be unbundled from the cost report.
11. The services of residents, nursing students, medical students, physician assistant students and APRN students cannot be billed under an APRN's NPI.
12. Employment relationships affect who has the right to bill for APRN services.
13. An APRN must accept the Medicare allowed amount as full payment for the services provided.

In the inpatient setting, some physician services provided by WOC APRNs are not billable to Medicare. For example, "rounding", initiating transfers, writing transfer orders, and writing orders to change an intravenous solution are not billable. These services are included in the treatment and communication services that are bundled and identified by Evaluation and Management (E/M) codes. When WOC APRNs evaluate and manage a patient's illness or injury through history taking, examination, and medical decision making, the work is billable because all of the required elements of the service have been performed. Hospital discharges are billable if the service includes performing the final examination of the patient, discussion of the hospital stay, instruction for continuing care to all caregivers, prescriptions and referral forms and preparation of discharge records. However, if WOC APRNs simply dictate the discharge summary and/or orders without performing the other functions, the service is not billable.

Nursing services provided during an inpatient stay are reimbursed through prospective payments. If WOC APRNs perform a complicated dressing change or pouching procedure which is a nursing service, it is not billable to Medicare.

Shared or Split Billing: Hospital Inpatient/Outpatient Clinic/Emergency Department

When two providers (e.g., physicians and WOC APRNs) from the same group practice perform a service for the same patient on the same calendar day, CMS allows the combined services to be reported under a single provider's NPI. The rendering provider listed on the Medicare claim can be *either* the physician (reimbursed at 100% of the PFS) or WOC APRN (reimbursed at 85%).

However, shared/split rules restrict the services reported to evaluation and management (E/M) services (not procedures) provided in the inpatient hospital, outpatient clinic, or emergency department.

CMS does not specify the extent of the billing provider's involvement, but this could be established by local Medicare contractor (MAC) requirements. The key to supporting a visit as being split/shared is the term "substantive." CMS defines it as at least some portion of the history, exam, and medical decision-making components of the E/M service. While both physicians and WOC APRNs must perform a "substantive" portion of the service, the guidelines indicate that WOC APRNs can perform the majority of the work, freeing up the physician to perform surgery or see more complex patients.

Shared/split rules require a face-to-face patient encounter by each provider on the same calendar day but not at the same time. There are no billing mandates requiring WOC APRNs to see the patient before the physician. Typically, WOC APRNs would see the patient first and create a note which the physician then adds to after seeing the patient later. Billing E/M visit as split/shared has a very important and unique requirement. Specifically, both physicians and WOC APRNs must document in the medical record what they personally contributed to the encounter. The combined documentation must support the overall level of service of the E/M visit. However, if there was no face-to-face encounter between the patient and the physician (for instance, the physician only reviewed the medical record) then the service must be billed under the WOC APRN's NPI. Although the visit level is supported by both provider services, only one claim may be submitted for a shared/split service.

Payment for pre-operative examinations and post-operative E/M for surgical patients is included in the global surgical package for surgery and not separately billable. The global package is a fixed fee intended to cover all treatment and services related to the surgical procedure, including pre-operative surgical visits, intraoperative services, and complications following surgery. It does not include the medical workup (e.g., history and physical, examination, testing, etc.) required to approve the surgical procedure.

Coding Basics: Current Procedural Terminology (CPT®) Codes

Current Procedural Terminology (CPT®) is a set of codes, descriptions, and guidelines maintained and copyrighted by the American Medical Association (AMA) and updated annually.⁶ It is Level I of the HCPCS (Health Care Common Procedure Coding System). CPT® codes provide a uniform language to accurately describe services rendered and provide an effective means for reliable nationwide communication between medical practitioners (e.g., WOC APRNs), patients, and third parties (such as Medicare and other insurers). Medicare and other payers use the CPT® codes to determine reimbursement rates.

Medical, surgical, diagnostic, and other procedures and services performed by healthcare professionals are identified by a five-digit number. The codes are listed by a main section (e.g., *Surgery*), sub-section (e.g., *Integumentary System*), sub-heading (e.g., *Skin, Subcutaneous, and Accessory Structures*), and finally procedures (e.g., *Debridement*). Guidelines at the beginning of each main section specify how to report the services and procedures within that set. These may include information such as:

- settings of services (e.g., office, hospital);
- special reports required as part of a service;
- guidelines for reporting more than one procedure/service;
- definition of services packaged into various codes.

An example of a Level I CPT® HCPCS procedure code is:

97597: Debridement (i.e., high pressure water jet with or without suction, sharp selective debridement with scissors, scalpel, and forceps) open wound (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area, first 20 sq. cm. or less.

Some of the procedures listed in the CPT® are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as “*add on*” codes. They are readily identified by specific descriptor nomenclature that includes phrases such as “each additional” or “list separately in addition to primary procedure.” Add on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code.

An example of an “add on” Level I CPT® HCPCS procedure code is:

97598: each additional 20 sq. cm. or part thereof (List separately in addition to code for primary procedure). Use 97598 in conjunction with 97597.

The CPT® also includes an Appendix of *modifiers*. These two-digit indicators are used to report or indicate that a service or procedure performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers allow WOC APRNs to effectively respond to payment policy requirements established by various entities. Modifiers cover one of the following alterations:

- Service/procedure had both a professional and technical component.
- Service/procedure was performed by more than one provider and/or in more than one location.
- Service/procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- Service/procedure was provided more than once.
- Unusual events occurred.

An example of a modifier is:

24 Unrelated Evaluation and Management Service by the Same Provider on the Same Day of the Procedure or Other Service. This is used when necessary to indicate that, on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided.

The CPT® *Place of Service and Facility Reporting* code set are used on claims to specify where the service was rendered. This code set is designated for reporting physician and qualified healthcare professional services or facility providers (e.g., hospitals) in specific circumstances. WOC APRNs should check with individual payers (e.g., Medicare, Medicaid, private insurers) for reimbursement policies regarding these codes.

Coding Basics: Evaluation and Management (E/M) Service Codes

Evaluation and Management (E/M) is the section of the CPT® containing codes which describe provider-patient encounters. Billing Medicare for E/M services requires selection of a code that best represents a) patient type; b) setting of service; and c) level of E/M performed.

Patient type: For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider. **New patient:** An individual

who did not receive any professional services from the physician or WOC APRN or another provider of the same specialty who belongs to the same group practice within the previous 3 years. **Established patient:** An individual who received professional services from the physician or WOC APRN or another provider who belongs to the same group practice within the previous 3 years.

Setting of service: E/M services are categorized into settings, depending on where the service is furnished. Examples include office/other outpatient setting; hospital inpatient; nursing facility; domiciliary setting; home visit.

Level of E/M performed: The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as determining the need for appropriate care. These levels encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of illness or injury. Each level of E/M services may be used by WOC APRNs.

There are three key components in selecting the appropriate level of E/M service provided: 1) extent of history obtained; 2) extent of examination performed; and 3) complexity of medical decision making.

Extent of history obtained: The types of history are defined as follows:

Problem focused: Chief complaint; brief history of present illness or problem.

Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent system review.

Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; **pertinent** past, family and/or social history **directly related to the patient's problems.**

Comprehensive: Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; **complete** past, family, and social history.

The table below depicts the elements required for each type of history.

Type of History	Chief Complaint	History of Present Illness	Review of Systems	Past, Family, and/or Social History
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focus	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Extended	Complete

Extent of examination performed: E/M services define four types of examination. An examination may involve several organ systems or a single organ system. The type and extent of the examination performed is based on clinical judgement, the patient's history, and nature of the presenting problem(s) and defined as follows:

Problem focused: A limited examination of the affected body area or organ system.

Expanded problem focused: A limited examination of the affected body area or organ system and other symptomatic or related body area(s) or organ system(s).

Detailed: An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).

Comprehensive: A general multisystem examination or a complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s)).

Complexity of medical decision making: Refers to the complexity of making a diagnosis and/or selecting management choice as determined by the following factors:

- Number of possible diagnoses or management options;
- The amount and/or complexity of medical records;
- Diagnostic tests and/or other information that must be obtained reviewed, and investigated;
- The risk of significant complications;
- Morbidity and/or mortality as well as co-morbidities associated with the patient's presenting problem(s);
- The diagnostic procedure(s) and/or potential management options.

The levels of E/M services recognize four types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in the table below must be met or exceeded.

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Documentation must demonstrate that the E/M service billed was medically necessary and appropriate for the diagnostic or therapeutic service provided and should include these seven key components:

- The chief complaint or reason for the visit and relevant history;
- Physical examination findings and prior diagnostic test results;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem; and
- Time spent with the patient.

CMS documentation guidelines provide extensive detail on how to determine the level of E/M service provided.⁴ WOC APRNs should carefully review this document and continue to follow these guidelines until changes are announced. CMS is working on a number of documentations, coding and payment changes for office/outpatient E/M visits over the next several years.

Effective in CY 2019, CMS has instituted the following changes in policy that impact WOC APRNs:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits: when relevant information is already contained in the medical record, WOC APRNs may choose to focus documentation on what has changed since the last visit or on pertinent items that have not changed. They do not need to re-record the defined list of required elements if there is evidence that the previous information was reviewed and updated as needed. WOC APRNs should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- For E/M office/outpatient visits for new and established patient visits: WOC APRNs do not need to re-enter information on the patient's chief complaint and history that has already been documented by ancillary staff or the beneficiary. WOC APRNs may simply indicate that the information was reviewed and verified.

In CY 2021, CMS will implement additional payment, coding, and other documentation changes. Payment for E/M visits will be simplified and vary based on attributes that do not require separate, complex documentation. CMS is finalizing the following policies:

- Reduce the payment variation for E/M office/outpatient visit levels by paying a single rate for levels 2 through 4 for established and new patients while maintaining the payment rate for office/outpatient visit level 5;
- Permit practitioners to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 documentation guidelines;
- Allow flexibility in how E/M office/outpatient levels 2 through 5 visits are documented and apply a minimum supporting documentation standard to level 2 visits;
- Allow practitioners to document the medical necessity of the visit based on a required amount of time spent face-to-face with the beneficiary;
- Implement add-on codes that describe the additional resources inherent in visits for primary care and non-procedural specialized care; and
- Adopt a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.⁷

Billing WOC Nursing Services: CPT® and E/M Codes

Codes listed here are not intended to be all-inclusive to every clinical practice and service that WOC APRNs may provide. In addition, WOC APRNs should review Medicare and other appropriate payer coverage policies to ensure correct coding for all billed procedures and services.

Ostomy care: WOC APRNs may use applicable E/M codes for new and established patients. For new patients these may include home visits (99341-99346); nursing facility (99304-99306); domicile/rest home (99324-99328); hospital initial care (99221-99223); and HOPD/office (99201-99205). For established patients: home visits (99347-99350); nursing facility (99307-99310); domicile/rest home (99334-99337); hospital subsequent care (99231-99233); and HOPD/office (99211-99215).

Wound care: CPT® identifies a number of codes. These include: incision and drainage (10060); surgical/excisional debridement (11042-11047), selective debridement (97597-97598); non-selective debridement (97602); tangential biopsy of skin (e.g., shave, scoop, saucerize, curette) single lesion (11102-3); punch biopsy of skin (including simple closure, when performed) single lesion (11104-5); incisional biopsy of skin (e.g., wedge, including simple closure, when performed) single lesion (11106-7); chemical cauterization of hypergranulation tissue (17250); application of Unna boot (29580); application of multilayer compression system (29581).

Debridement: Surgical/excisional debridement is the removal of viable tissue and requires (at a minimum) the debridement of subcutaneous tissue which may also include removal of epidermis and dermis, if performed. Debridement codes are assigned based on the level of tissue removed **not on wound depth or the tool used**. When performing debridement of a single wound, report depth using the deepest level of tissue removed. If multiple wounds are all debrided to the same

depth, the combined measurements of the debrided surface should be used to determine the appropriate code(s). The total surface area of each debrided wound must be documented separately. Each debridement may not be reported separately, unless performed on different tissue types.

“Active wound care procedures” include selective debridement codes and non-selective debridement. These are billed for the removal of nonviable tissue, including the epidermis and/or dermis. Although no living tissue is removed, the WOC APRN may use a sharp instrument for selective debridement. Non-selective procedures include removal of devitalized tissue without anesthesia by such means as wet-to-moist dressings, enzymes, abrasion, or larvae. However, this code is not separately payable. For application of an Unna boot or multilayer compression system, all related supply items are included in the payment.

The following are important Medicare guidelines that apply to wound care services⁸:

- Other than an initial evaluation, wound assessment is an integral part of all wound care service codes and is not separately billable;
- Initial wound assessments that are medically necessary may be reimbursed as a separately identifiable E/M service;
- Re-assessment/re-evaluation of a wound is a non-covered routine service. An exception would require documentation clearly supporting that there had been a significant improvement, decline, or change in the patient’s condition or functional status that was not anticipated in the plan of care and required further evaluation.
- It is generally inappropriate to report an E/M service in addition to a wound care service (e.g., debridement, application of a multilayer compression system);
- E/M can be reported in conjunction with wound care if, during the wound care encounter, the WOC APRN performs and documents a significant, separately identifiable service. The E/M service must be unrelated to the scheduled visit and require medical evaluation and treatment over and above that for the wound care.
- If E/M service is reported in addition to wound care, append modifier 25 (significant, separately identifiable E/M service by the same provider on the same day of the procedure);
- Medicare does not pay separately for dressing changes or patient/caregiver training in the care of the wound. These services are reimbursed as part of a billable E/M or procedure code that, commonly but not necessarily, occurs on the same date of the service as the dressing change.
- All topical applications are included in the payment for the procedure codes;
- A dressing change may not be billed as either a debridement or other wound service under any circumstances.
- The removal of secretions or wound cleansing does not represent a debridement service.

Skin biopsy: CPT® coding changes for 2019 include a set of six new skin biopsy codes (three primary codes, each with an add-on code). Using codes for tangential, punch, and incisional biopsies indicate that the WOC APRN is obtaining a tissue sample for a diagnostic

histopathologic exam and that the biopsy was performed independently or was distinct from any other services that were provided at the same encounter. Biopsies must be coded based on the **method of removal**, defined as follows:

- Tangential biopsy (11102 and 11103) comprises removal via shave, scoop, saucerization or curette. Performed with a sharp blade such as a flexible biopsy blade, obliquely oriented scalpel or curette, a sample of epidermal tissue is removed with or without portions of the underlying dermis.
 - Punch biopsy (11104 and 11105) requires using a punch tool to remove a full thickness cylindrical sample of the skin. The area of the punch biopsy is often marked prior to the procedure. Simple closure is included and cannot be billed separately.
 - Incisional biopsy (11106 and 11107) requires using a sharp blade (not a punch tool) to remove a full-thickness sample of tissue via a vertical incision or wedge, penetrating deep to the dermis, into the subcutaneous space.
- The following are pertinent coding guidelines for WOC APRNs performing skin biopsies:
- Documentation should include the anatomical site and the method of removal.
 - Only one primary biopsy code should be reported if more than one biopsy is performed at the same visit.
 - If multiple biopsies are performed with the same technique, report the corresponding biopsy code and then use the add-on code for each additional lesion that is biopsied.

Contenance services: Applicable CPT® codes for continence services that may be provided by WOC APRNs include: biofeedback training by any modality (90901); biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or Manometry (90911); rectal sensation, tone, and compliance test (91120); treatment of Incontinence by pulsing magnetic neuromodulation (53899); measurement of post-voiding residual urine and/or bladder capacity by ultrasound non-imaging (51798); change of bladder tube (51705); insertion of non-indwelling bladder catheter (51701); insertion of temporary indwelling bladder catheter (51702); bladder irrigation (51700).

National Correct Coding Initiative

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and control improper coding leading to inappropriate payment of Part B claims. The NCCI is updated annually and used by Medicare contractors to implement edits in their claims processing systems. The edits contained in the initiative serve to prevent improper payment when incorrect code combinations are reported. WOC APRNs should become familiar with the table of edits for physicians/practitioners as well as the table of edits for outpatient hospital services.

The NCCI does not include all possible combinations of correct coding edits or types of *unbundling* that exist. However, WOC APRNs are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Reviewing use of the edits will help determine if procedures may be reported together. The publication “How to Use the Medicare National Correct Coding Initiative (NCCI) Tools is available at:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf>.

Billing for Services: ICD-10-CM Codes

When billing Medicare and other payers, WOC APRNs must also report the patient's diagnoses to support the medical necessity for services provided. The code set used on all types of claims for services furnished is known as the International Classification of Diseases 10th Revision, Clinical Modification Coding System (ICD-10-CM). The ICD-10-CM is a morbidity classification published for classifying diagnoses and reason for visits in all health care settings in the United States. WOC APRNs are expected to code accurately following all ICD-10-CM guidelines provided by CMS and the National Center for Health Statistics.⁹ It is advised that WOC APRNs work closely with coders to help ensure complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters and are reported with their highest number of available characters. A 3-character code is used only if not further subdivided. A code is invalid if not reported to the full number of characters required, including the 7th character, if applicable. To select a code in the classification that corresponds to a diagnosis or reason for visit documented in the medical record, WOC APRNs should first locate the term in the Alphabetic Index, and then verify it in the Tabular List. Next, they should read and be guided by the instructional notations that appear in both of these locations to ensure selection of the correct code.

Medicare contractor (MAC) Local Coverage Determinations as well as National Coverage Determinations list the pertinent diagnosis codes that support medical necessity for services and supplies associated with that particular policy. WOC APRNs should be familiar with applicable MAC coverage determinations, such as *Wound Care*, and refer to them for ICD-10-CM coding instructions.

An example of an ICD-10-CM diagnosis code is:

L97.325: Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis.

Medicare Quality Payment Program (QPP)

The Medicare QPP is an incentive program which rewards high value, high quality clinicians with payment increases. It is also designed to reduce payments to clinicians who are not meeting performance standards established by CMS. Within the QPP, there are two tracks for participation: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). WOC APRNs would most likely participate in MIPS as individuals or as members of a group practice.

MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care. The MIPS performance year begins on January 1 and ends on December 31 each year. Program participants must report data collected during one calendar year by March 31 of the following calendar year to be eligible for a payment increase and to avoid a payment reduction.

WOC APRNs qualify under MIPS if they are an eligible clinician type and meet the low volume threshold (based on allowed charges for covered professional services under the Physician Fee Schedule and the number of Medicare Part B patients who are furnished covered services).

Performance is measured through data reported in four areas: Quality, Promoting Interoperability, Improvement Activities, and Cost. These four performance categories determine the final score which determines what the payment adjustment will be.

Quality: Includes the quality of the care delivered, based on performance measures created by CMS. WOC APRNs can select from the six measures of performance based on the clinical focus of their practice. **Promoting Interoperability:** Focuses on the electronic exchange of health information using certified electronic health record technology, including proactive sharing of information with other clinicians or the patient. It may include sharing test results, visit summaries, and therapeutic plans to coordinate care. **Improvement Activities:** Includes an inventory of activities that assess how WOC APRNs improve the care processes, enhance patient engagement in care, and increase access to care. The inventory allows WOC APRNs to select those activities most appropriate to clinical practice. **Cost:** Cost of care provided is calculated by CMS based on submitted Medicare claims.

Examples of wound care specific quality measures are:

- *Adequate offloading of diabetic foot ulcers at each visit.*
- *Adequate compression of venous leg ulcers at each visit.*
- *Nutritional assessment and intervention plan for patients living with chronic wounds and ulcers.*

Extensive information on the MIPS program is available at: <https://qpp.cms.gov/mips/overview>. In addition, CMS publishes several fact sheets to help WOC APRNs determine eligibility to participate in the program and how to submit claims data.¹⁰

Documenting to Support Medicare Payment for WOC Related Supplies: Level II HCPCS

The standardized coding system used to bill Medicare for medical supplies, drugs, devices, and some services not included in the CPT® is known as the Level II HCPCS. It is maintained and distributed by CMS and updated annually. These codes consist of a single alphabetical letter followed by four digits and a descriptor. Descriptors are generic whenever possible, but brand names are used to describe devices or drugs. This in no way implies that Medicare or any other insurer covers or reimburses for a given product.

HCPCS Level II also includes temporary codes assigned for procedures, professional services, or devices (known as “G”, “K”, “Q”, and “S” codes). “G” codes are assigned to procedures/professional services that do not have CPT® codes. “K” codes are established for the exclusive use of the DME MACs for processing Medicare Part B claims for supplies. “Q” codes are assigned to a number of categories and are unique in that they identify a product by brand name. Private insurers maintain the “S” codes. Items with these codes are not payable by Medicare.

An example of a Level II HCPCS alpha-numeric generic descriptor for a wound dressing is:

A6242: Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing.

WOC APRNs may write prescriptions for ostomy supplies, surgical dressings, and urological supplies. These are provided to Medicare beneficiaries under the Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. Supplies are separately billable for beneficiaries who reside at home, in assisted living, or a non-skilled nursing facility. Most medical supplies are not separately billable when a beneficiary is receiving care in a covered home health episode. The home health agency must provide the supplies and payment is included in the Medicare payment rate for home health.

To prevent payment denials, WOC APRNs must follow requirements established in the Local Coverage Determination (LCD) and Policy Article for the specific supply. These are published by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) assigned to the geographic location in which the beneficiary resides. In addition, these contractors post *Clinician Checklists* for ordering DMEPOS to help ensure documentation to support medical necessity for the supplies ordered.¹¹

Ostomy supplies: Medicare contractors require that the medical record contain adequate, clear documentation that corroborates the medical necessity for the amount of supplies ordered for the patient. For example, documentation must support that the beneficiary has a surgically created

opening (stoma) to divert urine or fecal contents outside the body and include location, construction, condition of the skin surrounding the stoma. In addition, there must be documented evidence of continued use of the supplies as well as the medical necessity for the amount ordered. Ostomy supplies are limited to a one-month supply for beneficiaries residing in a nursing facility and a three-month supply for beneficiaries at home. Insufficient documentation accounts for over 81% of improper payments. An important resource for WOC APRNs is the Medicare Learning Network *Provider Compliance Tips for Ostomy Supplies*¹² and the applicable DME MAC LCD and Policy Article: *Ostomy Supplies*.

Surgical dressings: Provisions defined in each DME MAC *Local Coverage Determination* must be met. There are also specific statutory payment policy requirements outlined in the *Surgical Dressings Policy Article* that accompanies the LCD. For example, coverage for surgical dressings is limited to certain wound etiologies and wounds that are surgically created or debrided.

Clinical documentation on wounds eligible for surgical dressings must include:

- Number of surgical/debrided wounds treated with a dressing; reason for and whether the dressing is being used as a primary or secondary dressing;
- Necessity for the type and amount of surgical dressings;

- Monthly or more frequent wound evaluations (more frequent for those in nursing facilities or with heavily draining/infected wounds). Assessment to include types of wounds, location, size, depth, drainage amount.

An order for surgical dressings must specify: type of dressing; size of the dressing; number/amount to be used at one time; frequency of the dressing change; and expected duration of need. If a patient requires more frequent dressing changes than what is defined by Medicare policy, documentation to support medical necessity must be submitted with the claim.

Insufficient documentation accounts for over 87% of improper payments for surgical dressings. An important resource for WOC APRNs is the Medicare Learning Network *Provider Compliance Tips for Surgical Dressings*¹³ and the applicable DME MAC LCD and Policy Article: *Surgical Dressings*.

Urological supplies: The Medicare Prosthetic device benefit covers urological supplies. To qualify for urological supplies, the beneficiary must have permanent urinary retention or urinary incontinence (defined as retention not expected to be corrected within 3 months). Urological supplies are **not** covered for temporary conditions. Documentation must support the clinical criteria specified in the LCD and Policy Article for the specific supply ordered, such as indwelling catheter, intermittent catheter, external urinary collection device, and urinary drainage collection systems. Insufficient documentation accounts for over 89% of improper payments. An important resource for WOC APRNs is the Medicare Learning Network *Provider Compliance Tips for Urological Supplies*¹⁴ and the applicable DME MAC LCD and Policy Article: *Urological Supplies*.

Recommendations

WOC APRNs billing for services under Medicare and any other insurers must be knowledgeable and up-to-date on coverage policies, correct coding, and documentation to support the level of service billed. The following are recommendations to assist with this mandate:

- Review and remain current on Medicare National and Local Coverage Determinations, Policy Articles, and applicable updates that provide medical necessity guidelines, utilization parameters, coding instructions, documentation requirements, and other pertinent information;
- Subscribe to receive ongoing updates from the applicable Medicare Administrative Contractor (MAC) that processes and pays claims for the geographic area where services are provided;
- Review Medicare Learning Network (MLN) publications relative to practice issues and subscribe to receive updates;
- Obtain new CPT®, HCPCS, and ICD-10-CM codebooks each year;
- Review and implement all new/ changed/deleted CPT®, HCPCS, and ICD-10-CM codes each year;
- Subscribe to the AMA monthly guidance document, the *CPT® Assistant* for ongoing coding guidance and review guidance articles related to surgical debridement, skin biopsy, and other procedures related to clinical practice;
- Review annual and quarterly updates to the National Correct Coding Initiative;

- Review and update payment information contained in the Medicare Physician Fee Schedule which is revised each year;
- Update Medicare beneficiary coinsurance and copayment/deductible amounts each year for correct billing;
- Follow the 1995 or 1997 E/M guidelines for new and established clinic/outpatient visit codes and codes for services rendered in other applicable settings until notice on CMS changes;
- Participate in the Medicare Quality Payment Program and report quality indicators as required;
- Subscribe to receive updates from the applicable DME MAC that processes and pays claims for DMEPOS supplies ordered for Medicare beneficiaries;
- Notify Medicare of any changes in employment that impacts assignment of benefits under an employer.

Summary

WOC APRNs have multiple opportunities to pursue reimbursement for services. Understanding Medicare coverage and payment policy, correct coding initiatives, and documentation requirements is critical for success. This fact sheet is intended to provide an overview of these issues. It is not meant to be an exhaustive authority on reimbursement. The information contained in this document may change at any time. The WOCN Society suggests that the reader review the references and follow the recommendations outlined above to remain current on reimbursement policy.

Glossary

Add-on code: Specific descriptor nomenclature in the CPT® that includes phrases such as “each additional” or “list separately in addition to primary procedure.” They are used to report procedures performed in addition to a primary procedure.

Advanced Practice Registered Nurse (APRN): A registered nurse, licensed by the State in which practicing, who has: 1) completed an accredited graduate level educational program to prepare for one of the four recognized advanced practice roles: clinical nurse specialist, nurse practitioner, nurse midwife, or nurse anesthetist; 2) passed a national certification examination that measures APRN role and population focused competencies; and 3) maintains continued competence as evidenced by recertification in the role and population through the national certification programs. (Adapted from the LACE consensus model.)

Assignment: The requirement that a provider accepts the amount allowed by Medicare as full payment for services provided to a beneficiary.

Current Procedural Terminology (CPT®): A set of codes, descriptions, and guidelines maintained and copyrighted by the American Medical Association (AMA) used by medical practitioners to report procedures/services performed for payment by Medicare and other insurers.

E/M Services: CPT® codes which describe medical practitioner-patient encounters and identify the patient as either new or established, depending on previous encounters.

Established patient: One who has received professional services from the WOC APRN or another physician/APRN of the exact same specialty and subspecialty that belongs to the same group practice, within the past three years.

Hospital Cost Report: An annual accounting submitted to Medicare containing provider information such as: facility characteristics, utilization data, cost, charges by cost center and financial statement data. This information is used by Medicare to provide reimbursement, collect statistics, and make payment calculations.

International Classification of Diseases, 10th Revision, Clinical Modification Coding System (ICD-10-CM): A code set that providers use to report medical diagnoses on all types of claims for services furnished.

Medicare: Federal health insurance program for the elderly and disabled. Part A covers hospitalization, hospice, skilled nursing facilities and some home care services; Part B covers physician services, outpatient hospital services, laboratory charges, medical equipment/supplies used in the home, and other home health services. The program is administered by the Center for Medicare and Medicaid Services (CMS). Claims are processed and paid by contractors called Medicare Administrative Contractors (MAC). Claims for medical equipment/supplies are processed and paid by contractors called Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Merit-based Incentive Payment System (MIPS): A quality of care improvement program established by the Centers for Medicare and Medicaid that ties provider payments to cost efficient care, intended to drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

Modifier: A two-digit indicator published in the CPT®. It provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

National Provider Identifier (NPI): A unique ten-digit identifier assigned by the National Plan and Provider Enumeration System to qualified physician and non-physician practitioners who bill Medicare and all other insurers for services.

New patient: One who has not received any professional services from the WOC APRN or another physician/APRN of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Physician Fee Schedule (PFS): The payment rate that Medicare allows for services, such as an office visit or a diagnostic procedure, performed by an eligible medical practitioner. WOC APRNs who bill Medicare under their own NPI are paid at 85% and must accept assignment; i.e., agree that the amount Medicare pays is full payment.

Unbundling: The use of several CPT® codes for a service or procedure when one inclusive code is available or the practice of expanding an all-inclusive service into individual units to maximize reimbursement.

References/Resources

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- ⁷ Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019. Available at: <https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-fee-schedule-calendar-year>. November 1, 2018. Accessed November 2, 2018.
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⁹Department of Health and Human Services. Centers for Medicare & Medicaid Services and the National Center for Health Statistics. ICD-10-CM Official Guidelines for Coding and Reporting FY 2019. Available at: <https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019final>. Accessed November 15, 2018.

¹⁰Department of Health and Human Services. Centers for Medicare & Medicaid Services. Quality Payment Program. QPP Participation Status Tool. Available at: <https://www.qpp.cms.gov/participation-lookup>. Accessed October 31, 2018.

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¹²Department of Health and Human Services. Centers for Medicare & Medicaid Services. MLN Matters. Provider Compliance Tips for Ostomy Supplies. ICN 909480. February 2018. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforOstomySupplies-ICN909480.pdf>. Accessed October 30, 2018.

¹³Department of Health and Human Services. Center for Medicare & Medicaid Services. MLN Matters. Provider Compliance Tips for Surgical Dressings. ICN 909475. February 2018. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforSurgicalDressings-ICN909475.pdf>. Accessed October 30, 2018.¹⁴

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