HHA Reimbursement for Disposable NPWT

Frequently Asked Questions
April 2018

Section I- BACKGROUND/OVERVIEW

Effective January 1, 2017, Medicare provides separate payment to home health agencies to furnish disposable negative pressure wound therapy (dNPWT)[1] .

Why has this new payment category been added for January 1, 2017?

The new payment category for disposable, non-durable, equipment was introduced by Congressional legislation at the end of 2015. Congress recognized that disposable NPWT may offer cost or clinical advantages over durable NPWT for select wound patients and that innovation may drive the replacement of other durable medical equipment with disposable options in the future. CMS will be monitoring utilization and costs of this therapy to patients receiving home health benefits and may adjust reimbursement amounts in the future.

Does this impact durable medical NPWT equipment, such as ACTIV.A.C.™ Therapy?

No. The new payment rule applies only to non-durable, or disposable, NPWT products . Traditional KCI V.A.C. ® Therapy products are considered durable medical equipment, or DME, paid through the original Medicare Part B DME benefit. DME is not paid or covered by the Home Health Agency benefit today nor will it be reimbursed going forward. DME products are billed directly by durable medical suppliers to the patient's insurance DME benefits. HHAs who treat patients with ACTIV.A.C.™ Therapy DME are not responsible for paying for the equipment, dressings and canisters, and **are not responsible for billing** or collection of payment for these DME items.

This does not impact ACTIV.A.C.™ disposables (dressings and canisters) used with durable medical units. This rule only applies to disposable NPWT devices such as SNAP™ Therapy System.

Section II- CODING, COVERAGE AND PAYMENT

How will disposable NPWT (dNPWT) reimbursement work for patients being treated by a Home Health Agency?

Under the new rule, HHAs may bill Medicare separately for the provision of exudate management collection system, application of dNPWT, the associated wound assessment, and instructions for ongoing care**.** This reimbursement will be **outside of, or in addition to**, an HHAs traditional 60-day episode bundled payment for providing home health services which is billed to Part A. The separate payment amount is billed to Part B, and is set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I HCPCS code, otherwise referred to as Current Procedural Terminology (CPT® 4) codes 97607/97608.

[1] Section 504 of the Consolidated Appropriations Act of 2016 provides certain Medicare beneficiaries access to dNPWT in their homes.

*CPT® 97607: "Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing **disposable, non-durable medical equipment including provision of exudate management collection system**, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters."*

*CPT® 97608: "Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing **disposable, non-durable medical equipment including provision of exudate management collection system**, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters."*

The reimbursement applies **only** when the entirely new, complete therapy device (cartridge/pump/canister) and dressing is provided with the wound assessment and application of therapy; it is a bundled payment to pay for the nursing time involved to assess the wound, apply the product and educate the patient, in addition to the acquisition cost of the complete dNPWT device supply. **Nurse visits to change a dressing *only* will be included in the 60-day episode bundled payment** and **will not be billed or reimbursed separately**.

HHAs must bill for dNPWT under Medicare Part B, outside of the traditional 60-day episode bundled payment.

What products are included in disposable NPWT category? Does this impact V.A.C.VIA™ NPWT and SNAP™ Therapy System or other NPWT products?

The disposable NPWT category is most easily defined as Single Patient Use NPWT devices that are discarded (disposed of) after use on one patient, and not maintained and re-used. The rule applies to products used for wound healing, in lieu of DME NPWT products. SNAP™ Therapy System and **V.A.C.VIA™ NPWT** are examples of dNPWT.

What is the reimbursement amount for the application of dNPWT in the Home Health setting?

The 2018 Medicare national average payment amount is $311 for the provision **and** application of a new therapy device, wound assessment, and education for the patient. This is adjusted by geography, just as payments for dNPWT are adjusted in the Wound Care Clinic (WCC) outpatient setting. Please be aware the reimbursement amount for dNPWT in the Home Health setting is set equal the reimbursement amount for the WCC.

This amount includes the Medicare reimbursement **and** the patient's 20% coinsurance; the WCC bills for and collects this co-insurance amount today and the HHA will need to bill for and collect this co-insurance amount starting in 2017.

Is reimbursement different based on size of wound, e.g. 97607 and 97608?

No. Reimbursement is the same for both codes and not impacted by the size of the wound.

If the wound size decreases to <50 do you change the CPT code?

Yes. The code should reflect the wound size on the date when dNPWT is provided.

What are the patient requirements for disposable NPWT?

Disposable NPWT is used in lieu of durable NPWT and indicated for the same types of acute and chronic wounds. The nurse and physician should determine if the patient's wound is clinically appropriate for dNPWT. SNAP™ Therapy is best considered for wounds less than 13 square cm and exudates levels less than 180ml per week. The prescribing clinician should determine when and if this therapy is needed.

Does this policy apply to all payers?

No. This reimbursement policy applies to original (fee-for-service) Medicare beneficiaries. Medicare patients typically represent between 50-80% of patients receiving home health. Additionally, Managed Medicare plans are required to offer the same coverage as Medicare fee-for-service, however the rates may vary. Commercial plans may or may not offer coverage. You may contact the Acelity Reimbursement Education Hotline for consultation if you have questions about commercial payer coverage on this product, or you may contact the patient's insurance directly.

How does this new policy differ from reimbursement for durable NPWT or advanced wound dressings?

HHAs are not reimbursed separately by Medicare use of advanced wound dressings when a patient is under a home health episode of care. For durable NPWT, or ACTIV.A.C.™, the HHA does not supply or pay for the equipment and supplies; it is provided to the patient and billed separately by the DME supplier (such as KCI). There are no changes to these reimbursement policies.

Prior to billing the Part B claim does the Request for Anticipated Payment (RAP) and final claim have to be billed for the HH episode or is it okay for just the RAP to be billed?

The RAP bill must be submitted to Medicare and processed before Part B billing of dNPWT is submitted.

Are dNPWT claims (34X) counted towards your episode visits count?

No, only 32X (nursing visits) count towards the episode visits.

Can Medicare certified Home Health agencies bill for and be reimbursed for dNPWT?

Yes, the current home health agency license allows Home Health agencies to bill for Medicare Part A and Part B as described in the Medicare claims processing manual Chapter 10-Home Health agency billing.

What is the name for the local wage adjustment index to be applied to the 97607? Where can it be found?

Contact your billing or Finance department for your adjustment factor, known as the Core Based Statistical Area (CBSA) wage index calculation.

Should an HHA request an ABN for the patient's co-insurance upfront from patients who receive dNPWT?

No. ABNs govern the process of notifying a patient of financial responsibility when a treatment, service or equipment is not expected to be covered by Medicare for a variety of reasons (such as not meeting coverage criteria, or a non-covered upgrade above what is currently covered). In these situations, an ABN is provided with specific information stating the reason for the non-coverage, patient's financial responsibility due to the non-coverage, and clarifies the patient will be responsible for such cost. It is required that providers bill for and make a good faith effort to collect the co-insurance from the patient's secondary insurance or the patient directly in the absence of supplemental or secondary insurance coverage. ABNs should not be used routinely nor do they apply for use in waivers of copays or deductibles where coverage is covered by Medicare.

Can we bill for visits captured on Type of Bill (TOB) 34X once the episode of care is closed as long as the skill was provided during an open episode of care?

Yes. The timely filing rule is twelve months; you have twelve months from the date of service to file a Medicare claim. Each date of service must fall within the date span of the episode.

Are the same Medicare restrictions applicable to disposable NPWT as durable NPWT?

The prescribing clinician will determine when and if this disposable therapy is needed as part of the Home Health Plan of Care., KCI's VTIAF (VAC THERAPY INSURANCE AUTHORIZATION FORM) applies only to Part B DME orders billed by KCI directly to Medicare, and is not required for dNPWT provided to the patient by the HHA in a Home Health Plan of Care. Please contact the Acelity Reimbursement Education Hotline at 800-668-6812 or your local Medicare Carrier for additional information.

Will a patient's secondary/supplemental Insurance pay their 20% co-insurance?

Yes. Supplemental plans typically pay as long as it is a Medicare covered service. Secondary insurance plans usually pay if Medicare pays, but eligibility and coverage verification should be performed before providing any service. For additional information, please call the Acelity Reimbursement Education Hotline at 1-800-668-6812 or email your inquiry to ReimbursementEducation@acelity.com (Please do not email patient information).

If a patient who is currently under a Home Health Plan of Care is seen at the WCC and furnished a SNAP™ Therapy System, how does the billing and reimbursement work?

Home Health Consolidated Billing was implemented as part of Home Health Prospective Payment System October 1, 2000. For all items listed on the Home Health Consolidated Billing list, only the Home Health Agency can bill institutional claims and receive reimbursement from Medicare for those items and services when provided to a Home Health patient currently under a Home Health Care Plan. Medicare assigns the HHA as the "Primary Provider" and all consolidated billing items furnished must be done so under arrangement with the HHA in order to receive payment from the HHA. Further information can be found at HHA Consolidated Billing MM3948.

Please note: DME items and physician services are excluded from HHA consolidated billing. Therefore, DME claims and physician's professional claims are paid by Medicare to those providers or suppliers directly.

Can a home health agency bill both 32X and 34X on the same day when both types of services were provided?

Yes, two separate claims should be submitted.

Are there any edits by CMS to determine if the HHA bills 34x and 32x claim on the same day?

Yes. The 34X claim can only be processed after the system shows the 32X claim has been submitted and processed. Allow about two weeks for the 32X claim to be in the system before submitting 34X claims.

Section III- BILLING AND DOCUMENTATION

Is our office set up to bill Medicare Part B separately from the 60-day episode payment?

You will need to verify and validate your billing software to ensure it is updated to process TOB 34X claims and arrange training for billing staff.

HHAs bill some other items separately from the 60-day bundled payment using the same claim type 34X used for dNPWT, examples: covered osteoporosis drugs, Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines. For all of these items the HHA bills Medicare separately on TOB 34X

and collects the patient's co-insurance.

How should we document the visit for application of dNPWT?

Comprehensive documentation is recommended for all activities performed for providing Home Health care in the patient's home. It will be critical to implement and train to a process for consistently documenting use and application of dNPWT for billing purposes. The document should support that all three components of the code were performed:

dNPWT application: list all supplies and equipment provided

Wound Assessment: Follow your HHA protocol to document wound assessment performed (e.g. measurements) and pay attention to CPT® wording.

Instructions for Ongoing Care: Document instructions provided and any patient education performed during the application of dNPWT.

As a reminder, if a new dNPWT is not applied, and only a dressing change is provided, use your normal documentation processes for Part A and do not bill separately for dNPWT for that visit.

Is a separate diagnosis needed on the claim for dNPWT beyond the wound diagnosis?

List all diagnoses related to the wound and dNPWT treatment on the claim.

Is the Home Health Agency responsible for supplying the dNPWT cartridge and dressing in order to bill the 34X visits?

Yes. The reimbursement applies **only** when the therapy device (cartridge and dressing) is provided by the HHA along with the wound assessment and application of therapy; it is a bundled payment to pay for the nursing time involved and acquisition cost of the dNPWT supply to the home health agency.

Section IV- ORDERING AND LOGISTICS

How do we order the SNAP™ Therapy System?

To order directly from Acelity, you will need to ensure an account is established by completing a New Account Setup Form, available from your local Representative or by calling the Acelity Advantage Center at 1-800-275-4524. Once your account is set up, you may order SNAP™ Therapy supplies through the Advantage Center by providing the part numbers you require and the shipping address. As a reminder, a valid Physician Rx is required before therapy is applied. Please contact your Acelity Sales rep if you would rather order through a Distributor.

What documentation does Acelity require to fill an order?

Shipping details and part numbers are required to place an order. Clinical details and information is not required for Acelity to fulfill an order. As a reminder, a valid Physician Rx is required before your agency applies therapy.

Can we order in single quantities for delivery next day?

Yes, HHAs are able to purchase SNAP™ Therapy dressings and cartridges on an individual item basis. Next day shipping is available if ordered by 3pm CST. Hospitals and Wound Care Clinics will continue to be set up to order in packages of ten.

Section V- OTHER

Can SNAP™ Therapy be used for the entire duration of therapy?

Yes, SNAP™ Therapy is indicated for chronic, acute, traumatic, sub acute and dehisced wounds, partial-thickness burns, ulcers (such as diabetic, venous or pressure), flaps and grafts.

SNAP™ Therapy is best considered for wounds less than 13 square cm and with exudate output of less than 180mL per week.

Section VI- ADDITIONAL RESOURCES

Is there any public information from CMS that we can share with our Agency?

A robust description of the rule and examples has been posted by NAHC: please go to http://www.nahc.org/NAHCReport/nr161130_1 .

Additionally, CMS has posted information on their Medicare Learning Network (MLN Matters® Number: MM9736) which may be accessed by this link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9736.pdf

MLN: Clarification of Billing and Payment Policies for NPWT Using a Disposable Device