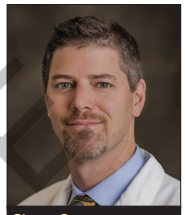
AUTHOR DISCLOSURES FOR THIS ISSUE OF *TWC:*

Kathleen D. Schaum, MS, is president and founder of Kathleen D. Schaum & Associates Inc., Lake Worth,FL; and director, medical products, reimbursement, at Smith & Nephew, Fort Worth, TX.

70 E. Swedesford Rd.
Suite 100
Malvern, PA 19355



# Guest Editorial: Place of Service 11 — A Private-Office Solution for Wound Center Survival


Shaun Carpenter, MD, FAPWCA, CWSP

The battle over the fate of Obamacare rages on, with a major area of debate centered around whether more people will be uninsured under the Republican plan. What isn't being discussed is the fact that currently there are millions of individuals who think they have insurance, but who actually don't because the policies they bought don't provide adequate coverage. Recently, I cared for a Houston man who became acutely ill while visiting Louisiana, only to find the insurance plan he had purchased when he retired was nearly worthless. The case illustrates why determining who is and isn't "insured" has a lot of fine print, why the Medicare Payment Advisory Commission that advises Congress on Medicare policy doesn't think the hospital outpatient system is worth the additional cost, and why the future of wound care services may be in the freestanding, private-office setting. Let me explain.

Hospital-based outpatient departments (HOPDs) specializing in wound care have grown in the last decade to more than 2,000 facilities nationwide. They provide a valuable service to patients and provide hospitals with a good source of revenue. Unfortunately, they also increase the cost of care for both the payer and the patient, because there is a hospital facility fee as well as a physician fee for each service. With copays as high as $150 per visit, many patients cannot afford weekly visits to their local HOPD, so some stop coming altogether. We may be going "back to the future" for wound care.

Tomorrow's wound clinic may be the private physician's office — the oldest, least expensive, and least regulated of all locations for patient care. Freestanding facilities like doctors' offices (place of service [POS] 11) bill a single fee for all services, often half the rate of services in the HOPD (POS 22). There are many advantages to opening a private-office wound center, such as no hospital bylaws, no administrators to answer to, and very few restraints on how one chooses to best heal patients. Payment plans can easily be worked out with patients like the "old-town doctors" of yesteryear. Wound specialists have the freedom to design customized healing protocols for specific patients, taking into account their insurance limitations and ability to cash pay. Medicare reimbursement for many procedures is higher in POS 11, in recognition of the fact that the physician is responsible for all of the overhead, supplies, and staffing. However, cellular and/or tissue-based products (CTPs) are not under "package pricing" in the private doctor's office. Another advantage is the ability to perform after-hour and weekend visits that allow for better patient access. The ability to add durable medical equipment services and direct-to-patient sale of products and nutritional supplements provides additional value and income in the private-office setting. Lastly, private-office hyperbaric oxygen therapy offers an intriguing future for improved outcomes, although that revenue model is challenging absent the hospital facility fee. The disadvantage of POS 11 boils down to one issue: cash flow. Many wound specialists can't afford to pay for rent, overhead, staffing, credentialing, human resources, coding, billing, wound dressing/supplies, CTPs, and equipment while waiting an unpredictable period of time for payers to reimburse. Unlike large hospitals, the single physician in a private office may live from month to month dangerously close to maxing out his/her credit limit. Solving the issue of cash flow is the key to success for the private-office wound center. In Hammond, LA, we've decided


to take that risk, with the construction of MedCentris (pictured above) in order to provide optimal care for underserved and underinsured patients who are in need of wound healing services.

Here's a real-life example: An 80-year-old woman has a Medicare managed care insurance plan. Her copay in the HOPD would be $150 per visit for weekly treatments. She lives with a venous leg ulcer that is 110 $cm^2$ and meets all the criteria for a CTP. The HOPD is reluctant to apply the CTP because the maximum allowable reimbursement for the visit under package pricing is $1,427, but the hospital cost of purchasing the product is $3,750 (a loss of $2,323). Furthermore, her copay for the facility alone is $285.40 and there is a separate copay for the physician application. However, at our office clinic (POS 11), she has one copay ($45) and is able to obtain the CTP because her insurance will reimburse the purchase price of the product plus an additional 6%. She received the treatment she needed and healed after two CTP applications, with cost savings to both the payer and the patient, and the practice was compensated for its services. It's possible that, as we move forward with healthcare reform and seek better outcomes at lower costs, tomorrow's wound clinic may be the private physician's office. ■

**Shaun Carpenter, MD, FAPWCA, CWSP**