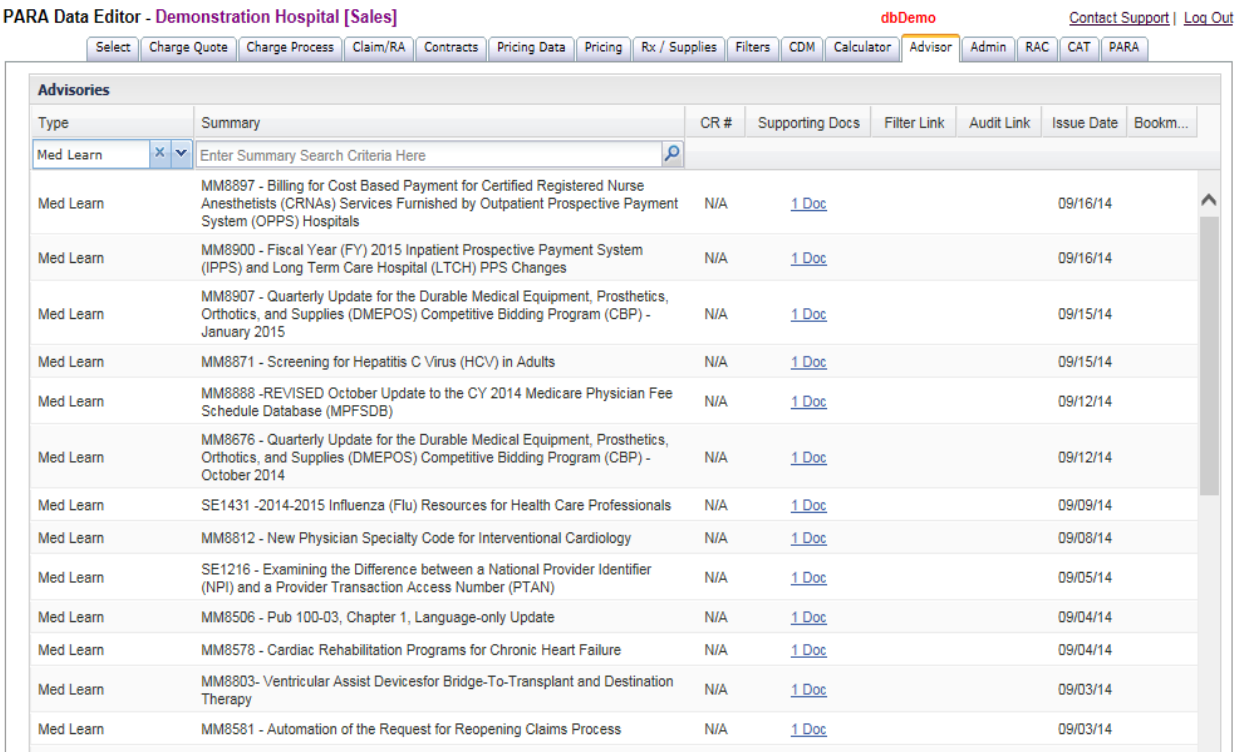
PARA Weekly Update – March 24, 2017

The following Departments are impacted by the contents of this week's update:

- **Patient Financial Services – see pages 1-45**
- **Hospital Administration - see page 45**
- **PDE Users – see pages 8, 9-11, 15**
- **HIM/Coding Staff – see pages 16-17, 22-44**
- **Supply Departments/DME Providers – see pages 3, 6**
- **Laboratory Departments – see pages 2, 7**
- **GI Laboratory – see pages 16-17**
- **Home Health Providers – see page 4**
- **OPPS Hospitals – see pages 12-14**
- **Wound Care Departments – see pages 22-44**

Med Learns:

There were three new or revised Med Learn articles released this week. All new and previous Med Learn Articles can be viewed under the type "Med Learn" in the Advisor tab:



Links to the Med Learns are also on the following pages.

Med Learns (continued)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9837.pdf

MLN Matters® Number: MM9837 Revised	**Related Change Request (CR) #: CR 9837**
Related CR Release Date: March 23, 2017	**Effective Date: January 1, 2018**
Related CR Transmittal #: R3740CP	**Implementation Date: July 3, 2017**

FISS Implementation of the Restructured Clinical Lab Fee Schedule

Note: This article was revised on March 23, 2017, to reflect the revised CR9837 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing CR9837 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for clinical laboratory providers submitting claims to Medicare Administrative Contractors (MACs) for services paid under the Clinical Lab Fee Schedule (CLFS) and provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9837 informs MACs about the changes to the Fiscal Intermediary Shared System (FISS) to incorporate the revised CLFS containing the National fee schedule rates. Make sure that your billing staffs are aware of these changes.

Background

Section 216 of Public Law 113-93, the "Protecting Access to Medicare Act of 2014," added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the CLFS. The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule "**Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule**" (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning on January 1, 2017, applicable laboratories will be required to submit private payor rate data to CMS. (See MLN Matters Article **SE1619** for further details of the laboratory data reporting requirements.) In

Med Learns (continued)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9886.pdf

MLN Matters® Number: MM9886	**Related Change Request (CR) #: CR 9886**
Related CR Release Date: March 24, 2017	**Effective Date: April 24, 2017**
Related CR Transmittal #: R705PI	**Implementation Date: April 24, 2017**

DMEPOS Order Requirements for Changing Suppliers

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What You Need to Know

Change Request (CR) 9886 instructs MACs to accept timely orders and medical documentation (so long as it meets Medicare requirements), regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from another, transferring supplier. Be aware that a new order is required in the following situations:

- There is a change in the order for the accessory, supply, drug, and so forth
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.
- When an item is replaced.
- When there is a change in the supplier, if the recipient supplier did not obtain a valid order for the DMEPOS item from the transferring supplier.

Background

The DMEPOS Competitive Bidding Program (CBP) uses competition among suppliers to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, while ensuring beneficiary access to quality items and services. Industry suggests that competition is bolstered and provider burden limited by allowing suppliers to accept medical documentation from other suppliers who previously held responsibility for that beneficiary. This change in the Centers for Medicare & Medicaid Services (CMS) instruction would permit MACs to accept timely orders and medical documentation, regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from a transferring supplier. This change is applicable to all suppliers.

Med Learns (continued)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17009.pdf

Denial of Home Health Payments When Required Patient Assessment Is Not Received – Additional Information

MLN Matters Number: SE17009 | Related Change Request (CR) Number: 9585

Article Release Date: March 24, 2017 | Effective Date: April 1, 2017

Related CR Transmittal Number: R3629CP | Implementation Date: April 3, 2017

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

In Change Request (CR) 9585, the Centers for Medicare & Medicaid Services (CMS) directed MACs to automate the denial of Home Health Prospective Payment System (HH PPS) claims when the condition of payment for submitting patient assessment data has not been met. CR9585 is effective on April 1, 2017. This article is a reminder of the upcoming change and provides further information to assist HHAs in avoiding problems with these Medicare requirements. Make sure that your billing staffs are aware of this change.

BACKGROUND

Per the Code of Federal Regulations (CFR) at 42 CFR 484.210(e), submission of an Outcome and Assessment Information Set (OASIS) assessment for all Home Health (HH) episodes of care is a condition of payment. In MLN Matters article MM9585, Medicare notified HHAs that effective for claims with dates of service on or after April 1, 2017, Medicare systems will increase enforcement of this condition of payment.

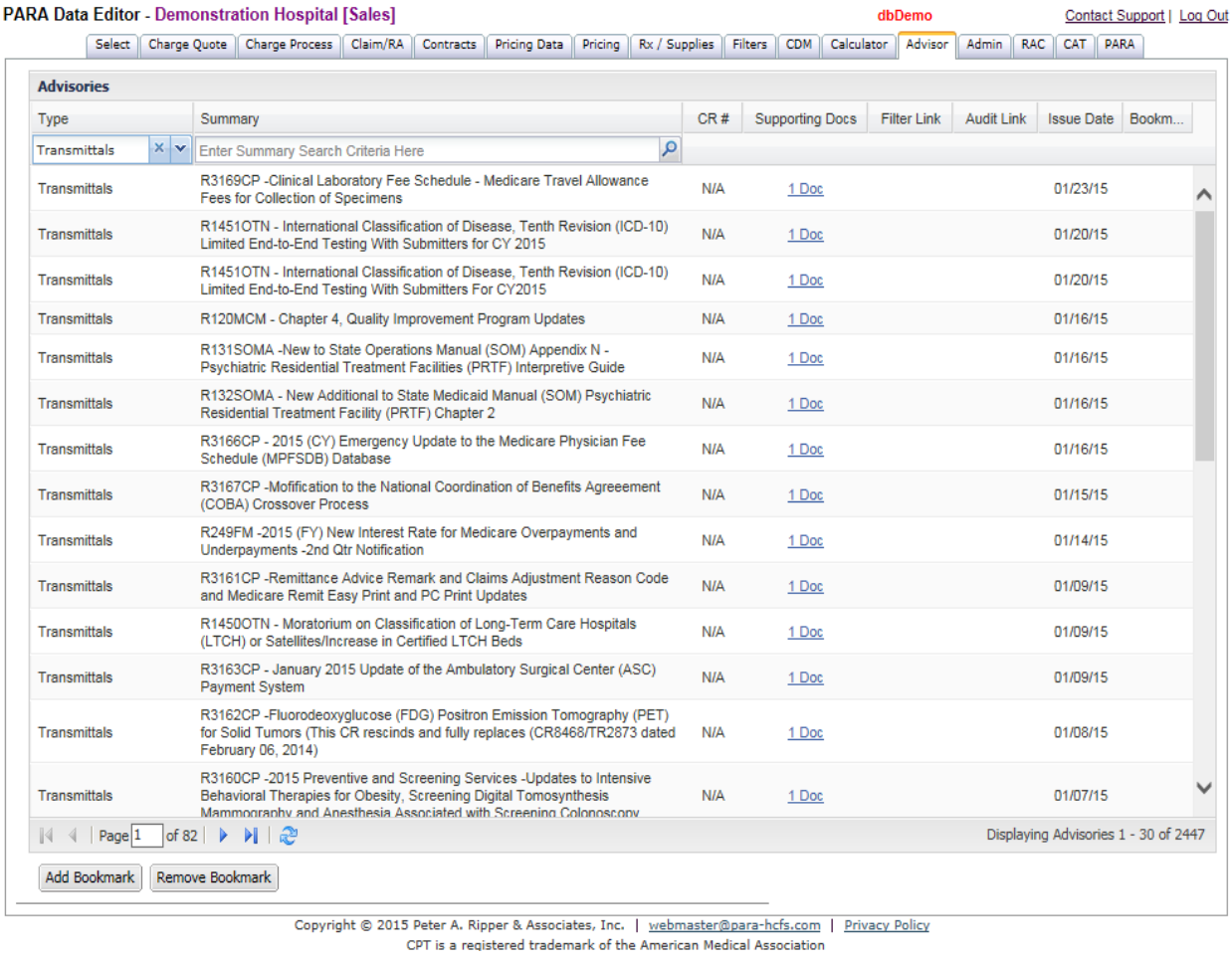
Claims Denied When an OASIS Assessment Has Not Been Submitted

OASIS reporting regulations require the OASIS to be transmitted within 30 days of completion. In most cases, this 30-day period will have elapsed by the time a 60-day episode of HH services is completed and the HHA submits the final claim for that episode to Medicare. Upon receipt of a final claim with service dates after April 1, 2017, Medicare systems will check whether the

Transmittals:

There were four new or revised Transmittals released by CMS this week. None of the Transmittals contained coding changes, so there are no links to your charge master.

All new and previous Transmittals can be viewed in the Advisor tab:



Links to the Transmittals are also on the following pages.

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R705PI.pdf

SUBJECT: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order Requirements for Changing Suppliers

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to instruct contractors to accept timely orders and medical documentation, regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from another, transferring supplier.

EFFECTIVE DATE: April 24, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 24, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1808OTN.pdf

SUBJECT: Advanced Provider Screening (APS) Phase 1 Go-Live

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to initiate phase one of APS criminal screening.

EFFECTIVE DATE: May 15, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1809OTN.pdf

SUBJECT: Client Letter v5.2 Upgrade - DME MAC Training and Testing

I. SUMMARY OF CHANGES: Client Letter v4.6 is a Commercial-Off-The-Shelf (COTS) product used by the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs). Top Down, the application developer, notified customers that they would no longer support version lower than v5.0, but agreed to provide support for VMS through September 30, 2017. Client Letter v5.2 is the latest version and will be implemented over two releases. The July 2017 release will focus on hardware and software acquisition and installations; letter template conversions; application setup and tuning. The October 2017 release will focus on testing and implementation. Client Letter v5.2 upgrade will be implemented in October 2017. The DME MACs will receive training on application changes, and test the v5.2 changes and the print vendor process.

EFFECTIVE DATE: April 24, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 24, 2017

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3740CP.pdf

Transmittal 3653, dated November 10, 2016, is being rescinded and replaced by Transmittal 3740, dated, March 23, 2017 to revise business requirement 1.2 removing the decimal point in the rate field, and to indicate which digits are dollars and cents in order to make the new CLFS consistent with other pricing files. Attachment CLFS File Layout-Text File has also been removed from the CR. All other information remains the same.

SUBJECT: FISS Implementation of the Restructured Clinical Lab Fee Schedule

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the Fiscal Intermediary Shared System (FISS) to incorporate into the shared system, the revised Clinical Lab Fee Schedule (CLFS) containing the National fee schedule rates.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017 - For requirements, design, and coding; July 3, 2017 - For testing and implementation

PDE Update – Select Tab – Bulletin Board Updates

The following table lists the articles that were added to the Bulletin Board in the past week:

Date	Description
3/26/2017	Anthem Blue Cross Provider Communications -Important Changes to Anthem Blue Cross' National Drug List - Formulary
3/26/2017	AHRQ News Now: special Patient Safety Awareness Week issue
3/26/2017	AHRQ Toolkit Designed to Reduce Urinary Tract Infections in Long-Term Care
3/26/2017	AHRQ News Now: prostate cancer surgery, new grantee profile, new patient safety research
3/26/2017	AHRQ What's New | March 22, 2017
3/21/2017	PARA Weekly Update 3/17/2017

PARA Data Editor (PDE) Data Table Updates

Below is a list of the Data Tables utilized throughout the **PDE**, and the frequency of their issued updates. **PARA** is continually updating these tables as their new data becomes available.

Item Name	Update Frequency
AL Medicaid	Annually
Ambulance Fee Schedule	Annually
AR Medicaid	Annually
ASC payment rates	Annually
ASP Drug Pricing Files	Quarterly
AZ Medicaid	Annually
CA Medi - Cal	Monthly
Calculator link "review Payment Status Indicator"-Addendum D1	Annually
Clinical Laboratory Fee Schedule	Annually
CO Medicaid	Annually
CPT Data Files	Annually
DE Medicaid	Annually
Device, Radiolabeled Product, and Procedure Edits	Quarterly
DRG Table 5	Annually
Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedules	Annually
Final Rule Hospital Wage Index	Annually
FL Medicaid	Annually
HCPCS File	Quarterly
HI Medicaid	Annually
IA Medicaid	Annually
ICD-9 Diagnosis and Procedure Codes and Their Abbreviated Titles	Annually
ICD-9-CM Codes	Annually
ICD9 to ICD10 Crosswalk	Annually
ICD-10 Codes	Annually
ID Medicaid	Monthly
IL Medicaid	Annually
IL Medicaid DME	Annually
IN Medicaid	Annually
Integrated Outpatient Code Editor (I/OCE) Specifications Version	Quarterly
Interventional Radiology	Annually
J-Code Chemo Admin List	Annually
J-Code Chemo Admin List	Annually
J-Code Chemo Admin List	Annually

PARA Data Editor (PDE) Data Table Updates (continued)

Item Name	Update Frequency
KS Medicaid	Annually
KY Medicaid	Annually
LA Medicaid	Annually
LCD - LMRP	Weekly
ME Medicaid	Annually
Medicaid NCCI Edits	Quarterly
Medically Unlikely Edits	Quarterly
Medicare Preventative Services Quick Reference Chart	Annually
MEDPAR Limited Data Set	Annually
MI Medicaid	Quarterly
MN Medicaid	Monthly
MO Medicaid	Annually
MS Medicaid	Annually
MS-DRGs	Annually
MT Medicaid	Annually
NC Medicaid	Annually
NCCI Edit Manual	Annually
NCCI Edits - Hospital Outpatient PPS	Quarterly
NCCI Edits - Physicians	Quarterly
NCD Lab	Quarterly
ND Medicaid	Annually
NDC - First Data Bank Data	Weekly
NDC/HCPCS Crosswalk	Quarterly
NE Medicaid	Annually
NH Medicaid	Annually
NJ Medicaid	Annually
NM Medicaid	Annually
NPI	Quarterly
NV Medicaid	Annually
NY Medicaid	Annually
OH Medicaid	Annually
OK Medicaid	Annually
OPPS Addenda	Annually
OR Medicaid	Monthly

PARA Data Editor (PDE) Data Table Updates (continued)

Item Name	Update Frequency
Outpatient Limited Data Set (limited)	Annually
Outpatient Standard Analytical File (expanded)	Annually
Physicians fee schedule	Quarterly
Physicians RVU	Quarterly
Provider Compliance Newsletter	Quarterly
RI Medicaid	Annually
SD Medicaid	Annually
Self Administered Drug Quarterly Update- FI/MAC	Annually
SNF MEDPAR Limited Data Set	Annually
Supplier Data- Phys/Supplier Procedure Summary Master File	Annually
Tricare No-Pay List	Quarterly
Tricare ProcCodeNumberofService Limits	Quarterly
TriCare Questionable Covered Services	Quarterly
TX Medicaid	Annually
Updates of Addendum A and B	Quarterly
VT Medicaid	Annually
WA Medicaid	Quarterly
Wage indexes for each provider ID	Annually
WI Medicaid	Annually
WV Medicaid	Annually
WY Medicaid	Weekly
ZIP code to Carrier Locality File	Annually

CMS April 2017 OPPS Quarterly Update

CMS published the quarterly update to OPPS, effective April 1, 2017, at the following link:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3728CP.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3728	Date: March 3, 2017
	Change Request 10005

During the week of March 20, PARA will provide its charge master clients with a spreadsheet listing any CDM line items which correspond to HCPCS codes affected by the Medicare update. Please look for instructions in the PARA Weekly Update to be released on March 22 for further information.

The CMS update includes the following points:

- **3 new proprietary lab codes** will be covered by Medicare effective 4/1/17; The three new tests are:

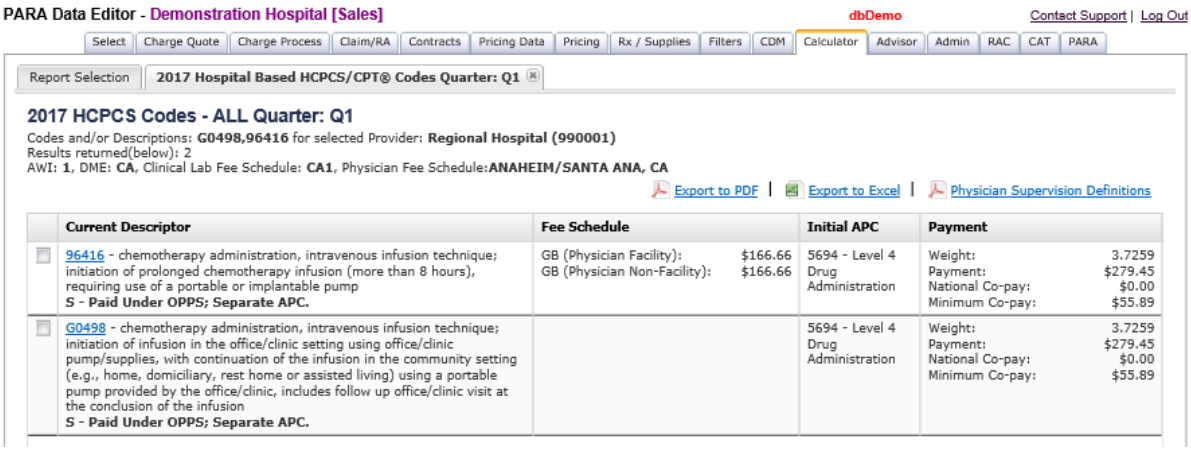
Code	Long Descriptor	OPPS Status
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported	A
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps	Q4
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score	Q4

- **Drug Screen HCPCS G0477-G0479** are officially deleted in favor of CPT's 80305-80307; the new 2017 CPT's 80305, 80306, and 80307 are nearly identical to the G-codes, therefore Medicare has discontinued the G-codes. PARA clients were advised of this change at year-end 2016 within the 2017 Coding Update documents at: https://apps.para-hcfs.com/para/Documents/2017_Drug_Testing_Code_Update_Rev_12272016_edited.pdf

- **Reporting prolonged chemotherapy with new HCPSC G0498 is clarified**. In mid-2016, Medicare created G0498 (chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion.)

G0498 - continued

Previously, chemotherapy providers may have billed 96416 for this service.



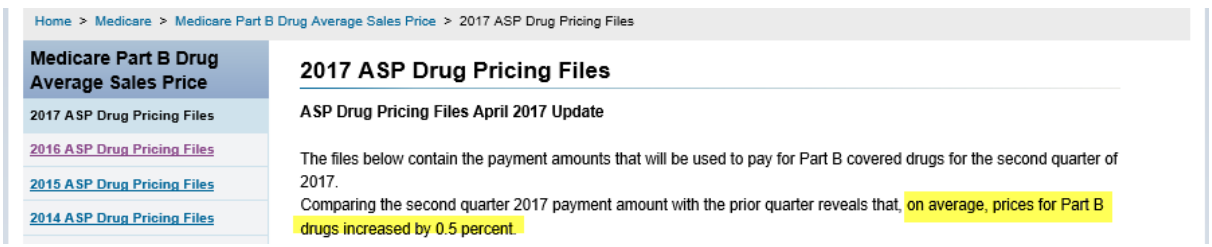
The new HCPCS G0498 differs from CPT 96416 for prolonged chemotherapy in that it specifies:

1) the portable infusion pumps are supplied by the clinic or outpatient department;
2) the infusion service is continued in the "community setting"; and
3) No minimum number of hours for the prolonged infusion is defined; and
4) The outpatient visit at the conclusion of the infusion is not separately billable, as it is included within the G0498 code description.

PARA recommends billing G0498 for prolonged chemotherapy which is initiated in the outpatient hospital setting, but continued in the community setting. Hospitals are cautioned that the subsequent visit for the disconnection/discontinuation of the infusion is included in G0498 (not separately billable.) If the hospital does not supply the portable pump, modifier 52 for reduced services is appropriate for this HCPCS.

- **Providers are advised that implant code C1842 for the Argus Retinal Prosthesis is appropriate for ASC reporting only**, and should not be used for hospital outpatient claim reporting.

- **The Average Sales Price database will update drug reimbursement by an average increase by 0.5%** through the usual quarterly update of reimbursement rates for separately payable drugs under OPPS. The ASP files are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2017ASPFiles.html



- **Seven drugs were added to the list of separately payable drugs** with pass-through status G; five of the seven have newly assigned C-codes. These will become separately payable as of 4/1/17:

HCPCS Code	Long Descriptor	APC	Status Indicator
C9484	Injection, eteplirsen, 10 mg	9484	G
C9485	Injection, olaratumab, 10 mg	9485	G
C9486	Injection, granisetron extended release, 0.1 mg	9486	G
C9487	Ustekinumab, for intravenous injection, 1 mg	9487	G
C9488	Injection, conivaptan hydrochloride, 1 mg	9488	G
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	1862	G
Q5102	Injection, infliximab, biosimilar, 10 mg	1847	G

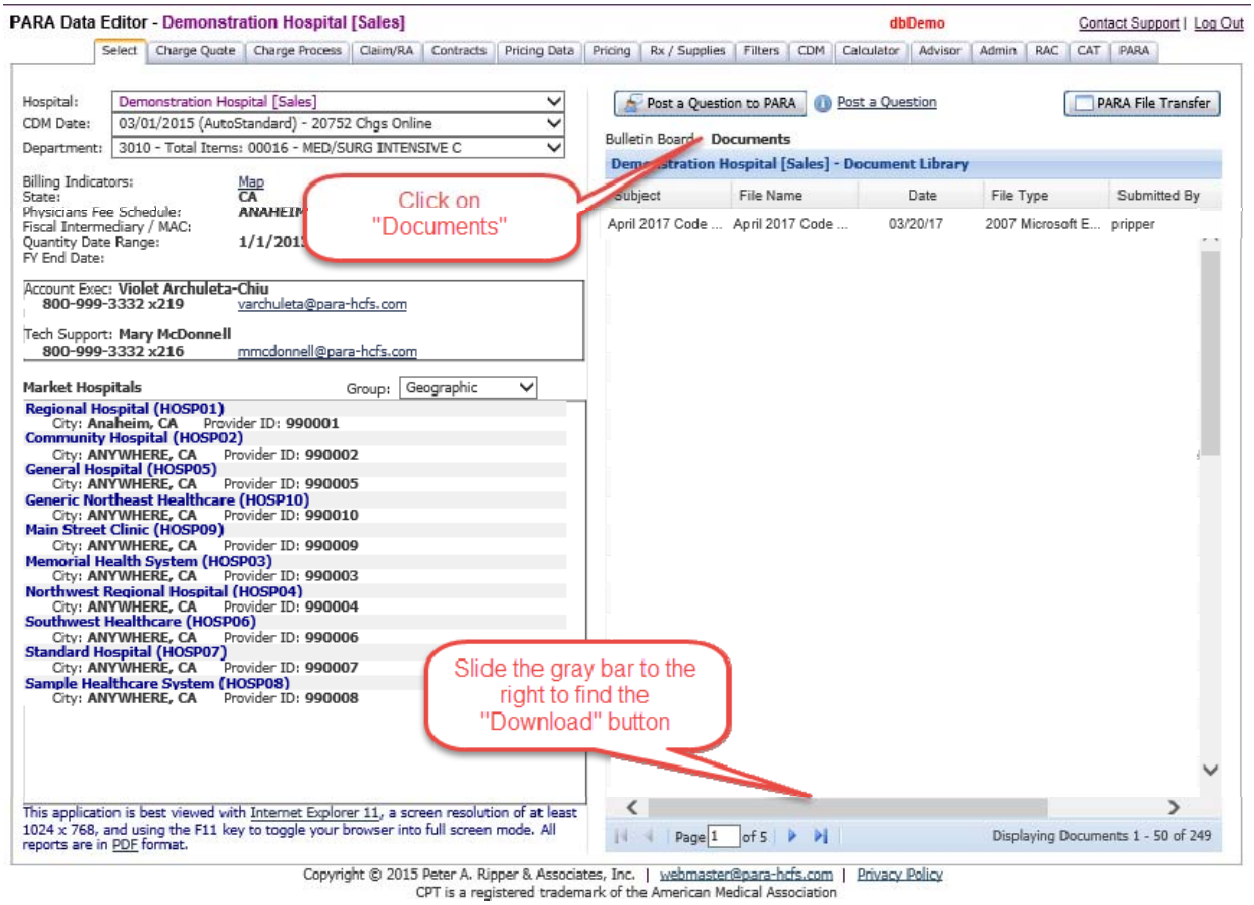
- **The OPPS status for J1130 (injection, diclofenac sodium, 0.5 mg) was changed** from E2 (excluded) to K (separately payable) retroactive to 1/1/17. CMS had temporarily discontinued coverage of this drug while it reassessed the reimbursement rate. Now that pricing data has been evaluated successfully, CMS is covering the drug retroactive to 1/1/17.

- **Four skin substitute HCPCs were reassigned** from the low-cost to the high-cost category; specifically:

HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
Q4161	Bio-Connekt per square cm	N	High
Q4169	Artacent wound, per square cm	N	High
Q4173	Palingen or palingen xplus, per sq cm	N	High
Q4175	Miroderm, per square cm	N	High

- CMS corrected a prior error by removing from the skin substitute list HCPCS Q4171 Interfyl, 1 mg, which should not have been listed as a skin substitute at all.

PARA clients will find a list of charge master line items which are potentially affected by the April 2017 OPPS update in the **PARA Data Editor**. The spreadsheet can be downloaded by logging into the **PDE**, toggling the bulletin board on the right hand side to "Documents", and locating the item at or near the top of the list entitled "April 2017 Code Map Update":



Note that some smaller facilities may not have any charges affected by the update.

PARA suggests a careful review of pharmacy line items to verify that the drug in the CDM precisely matches the new HCPCS code. For example, the drug granisetron (aka Kytril) may be coded J1626 currently; this J-code would continue to be accurate even after 4/1/17 if the granisetron drug is not the "extended release" formulation identified in the new HCPCS C9486.

Please contact **PARA** with any questions or concerns by using the "Post a Question" feature on the home page of the **PARA Data Editor**.

Question #1: What is the difference between a screening and a diagnostic colonoscopy?

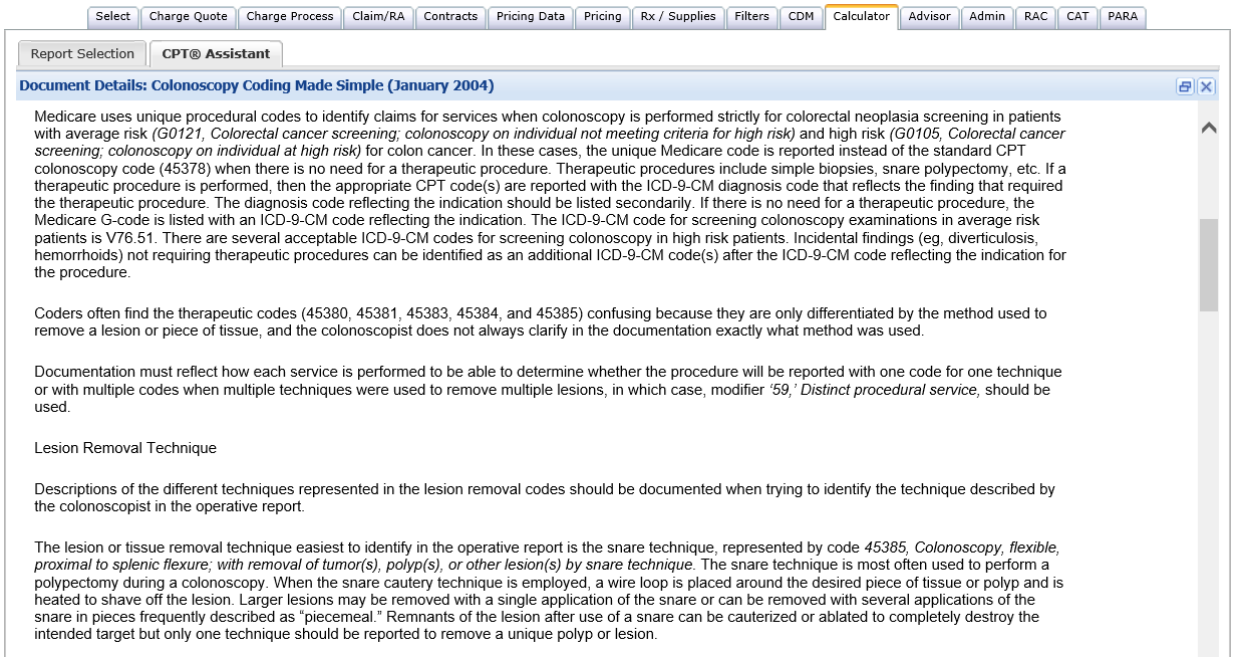
Answer: A screening colonoscopy is a procedure performed on a patient who has no current symptoms. The physician order should also state "screening" as the indication for the colonoscopy. The patient may have had a history of polyps or a family history of colon or rectal cancer.

A diagnostic colonoscopy is performed when a patient has related symptoms or has a polyp removed during the procedure. A diagnostic colonoscopy may be ordered for a patient who experiences diarrhea, abdominal pain, rectal bleeding or other related symptoms.

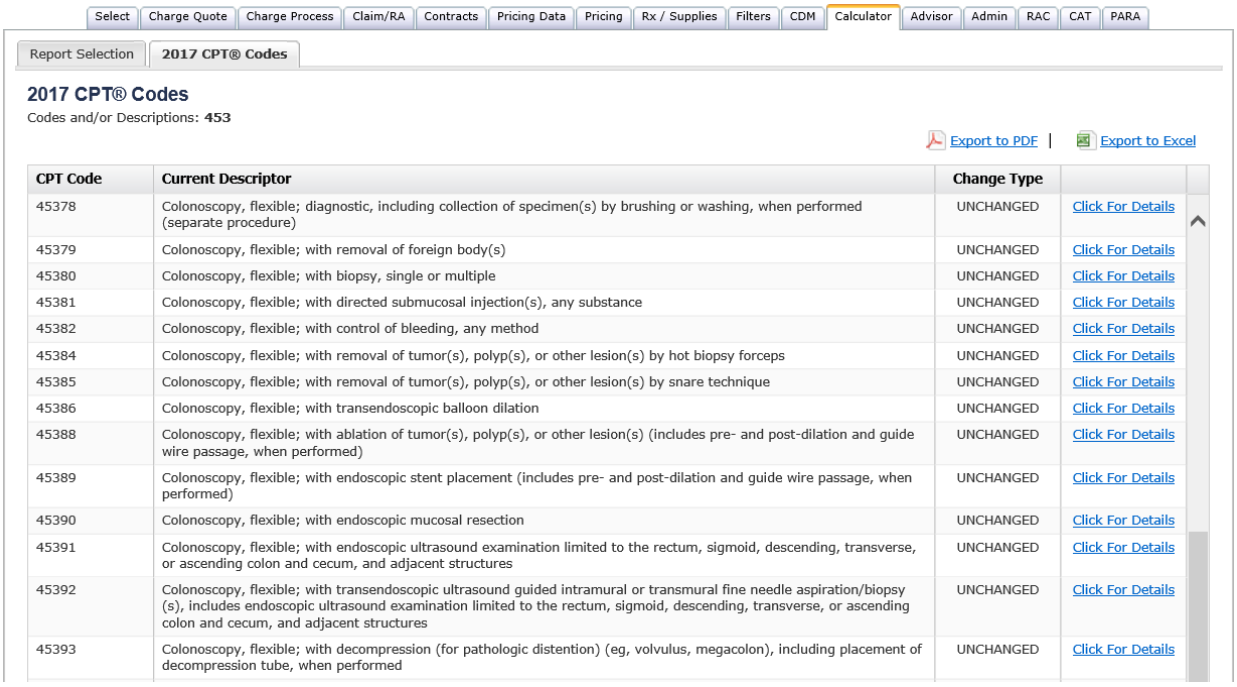
Question #2: What is the appropriate CPT®/HCPCS code to report for a screening colonoscopy versus a diagnostic colonoscopy?

Answer: For a screening colonoscopy, code selection is based on whether the patient is high risk versus average risk and whether the patient has Medicare insurance. Medicare created unique HCPCS codes to identify a colonoscopy performed strictly for screening in patients with average risk (G0121) and high risk (G0105) for colon cancer.

For patients that do not have Medicare insurance, report CPT® code 45378 when there is no need for a therapeutic treatment as instructed in the AMA CPT® Assistant 2004 January reference. Facilities should check with their local carriers or local third-party payers for their specific reporting guidelines regarding these services. Please refer to the **PARA Data Editor** reference AMA CPT® Assistant, 2004 January pg 4.



For a diagnostic colonoscopy, code selection is based on the method and technique of treatment involved in the procedure (i.e. removal of tumor, control of bleeding, etc). Please refer to the **PARA Data Editor** code descriptions.



Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Report Selection | 2017 CPT® Codes

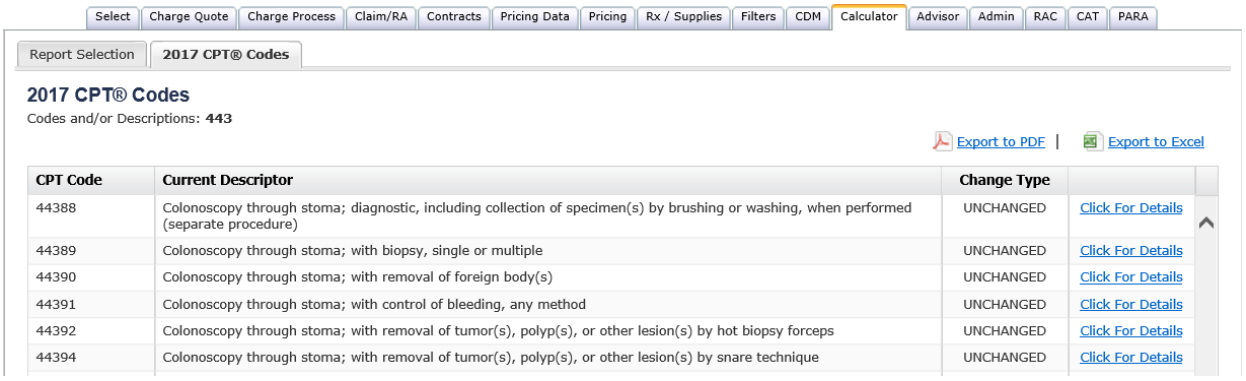
2017 CPT® Codes

Codes and/or Descriptions: **453**

Export to PDF | Export to Excel

CPT Code	Current Descriptor	Change Type	
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	UNCHANGED	Click For Details
45379	Colonoscopy, flexible; with removal of foreign body(s)	UNCHANGED	Click For Details
45380	Colonoscopy, flexible; with biopsy, single or multiple	UNCHANGED	Click For Details
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	UNCHANGED	Click For Details
45382	Colonoscopy, flexible; with control of bleeding, any method	UNCHANGED	Click For Details
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	UNCHANGED	Click For Details
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	UNCHANGED	Click For Details
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	UNCHANGED	Click For Details
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	UNCHANGED	Click For Details
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	UNCHANGED	Click For Details
45390	Colonoscopy, flexible; with endoscopic mucosal resection	UNCHANGED	Click For Details
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	UNCHANGED	Click For Details
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy (s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	UNCHANGED	Click For Details
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	UNCHANGED	Click For Details

Colonoscopy through stoma is the examination of the colon, from the stoma to the cecum, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. Please refer to the **PARA Data Editor** code descriptions.



Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Report Selection | 2017 CPT® Codes

2017 CPT® Codes

Codes and/or Descriptions: **443**

Export to PDF | Export to Excel

CPT Code	Current Descriptor	Change Type	
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	UNCHANGED	Click For Details
44389	Colonoscopy through stoma; with biopsy, single or multiple	UNCHANGED	Click For Details
44390	Colonoscopy through stoma; with removal of foreign body(s)	UNCHANGED	Click For Details
44391	Colonoscopy through stoma; with control of bleeding, any method	UNCHANGED	Click For Details
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	UNCHANGED	Click For Details
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	UNCHANGED	Click For Details

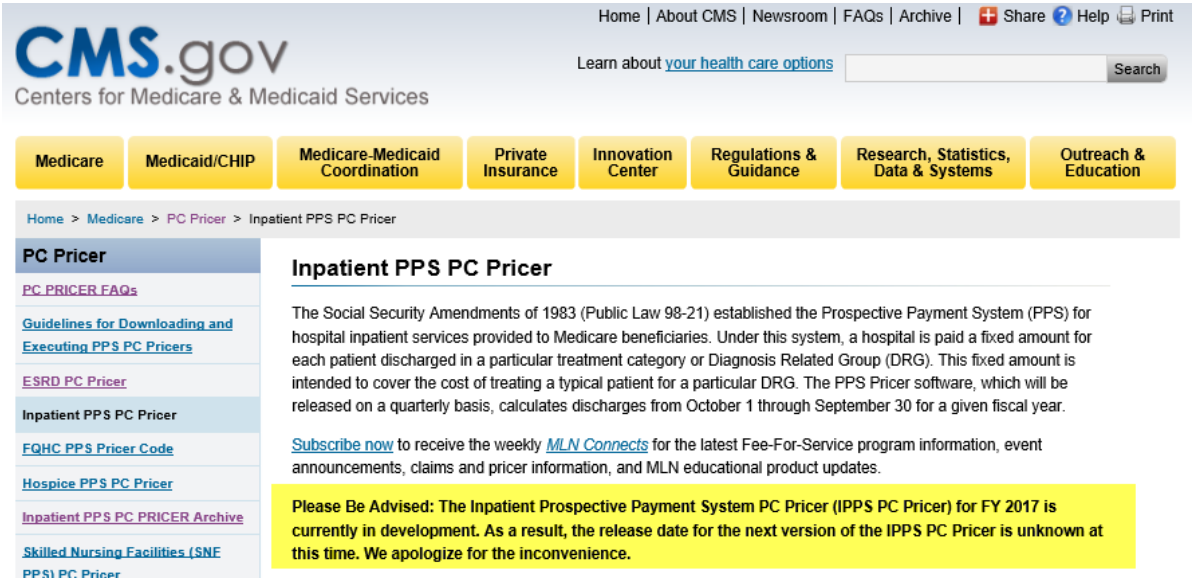
Question: How can I get a DRG rate on a Medicare inpatient stay? For example, a 3 day inpatient admission grouping to DRG code 743. Along the same lines, how can the cost outlier threshold be determined for a given stay?

Answer: So far this year, Medicare has not provided the Pricer software with which providers can calculate DRG payments. We can use the 2016 Pricer to estimate the current payment for a given DRG based on rates and factors that were in effect for each facility last year, or **PARA** can calculate the DRG manually if the hospital rate sheet is provided.

Normally, CMS publishes its IPPS PC Pricer, a downloadable software package which calculates variable data into accurate DRG payments for each individual provider. However, as of this date (3/22/2017), Medicare has not released the current year PC Pricer.

According to Medicare's Inpatient PPS PC Pricer website, the 2017 software is "in development. As a result, the release date for the next version of the IPPS PC Pricer is unknown at this time."

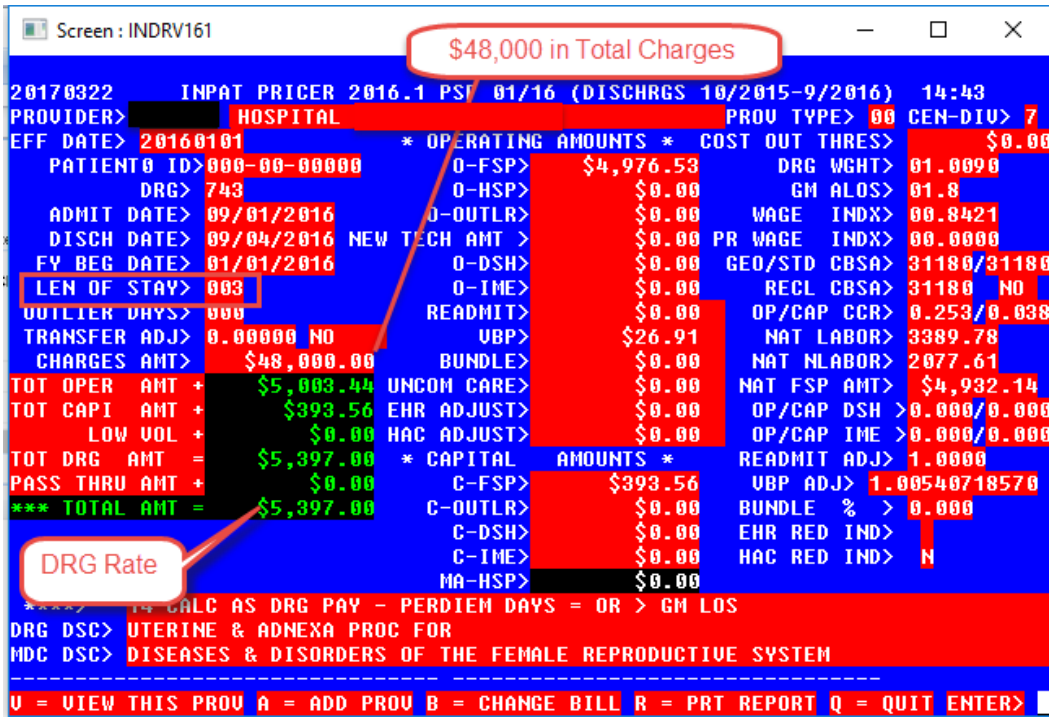
https://www.cms.gov/medicare/medicare-fee-for-service-payment/pcpricer/inpatient.html



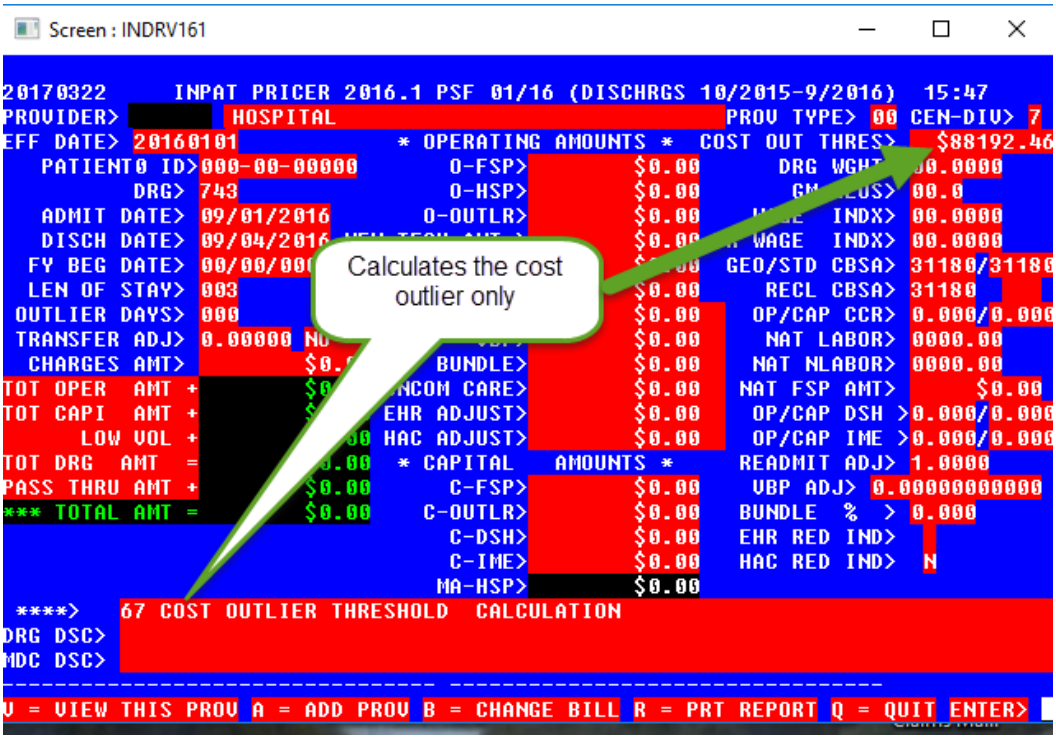
The software allows users to enter the variables which impact reimbursement, such as the provider number, admit date, discharge date, DRG, and total billed charges (among other factors). The PC pricer calculates Medicare's reimbursement taking into account both operating and capital amounts, the uncompensated care payment, penalties for quality issues such as a high readmission rate, and an adjustment (up or down) for value-based purchasing.

The absence of this important information has implications beyond payment validation. Noridian, a Medicare Administrative Contractor (MAC) in the West and Northwest, has informed Part A facilities that it is not in a position to calculate reimbursement for outlier cases without the Pricer software.

Here's a screenshot of the 2016 PC Pricer for DRG 743, calculated at rates appropriate for a particular hospital (provider ID redacted) at FY 2016 rates:



The PC Pricer may also be used to calculate the cost outlier alone, as indicated in the following report:



Chapter 3 of the Medicare Claims Processing Manual affirms that the Pricer is the source of information for calculating cost outlier cases:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

20.1.2 - Outliers

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

§1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

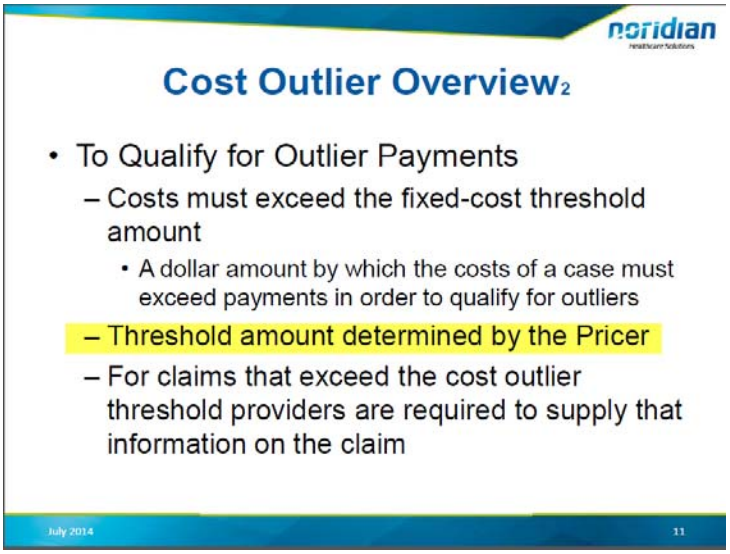
The actual determination of whether a case qualifies for outlier payments is made by the Medicare contractor using Pricer, which takes into account both operating and capital costs and Medicare severity-diagnostic related group (MS-DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn MS-DRGs). Any outlier payment due is added to the MS-DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit the CMS Web site at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

The Medicare contractor may choose to review outliers if data analysis deems it a priority.

The MAC's dependency on Pricer software is confirmed by the following slide from a Noridian presentation published in 2014:

https://med.noridianmedicare.com/documents/10521/2053666/materials_ipps_cost_outliers_2014.pdf/0dfc50d1-4bdf-4943-b1e7-b25646fa5b7c



PARA encourages providers with claims pended due to the absence of Pricer data for 2017 to obtain written confirmation of the source problem from the MAC, and then request assistance from your local congressperson (House of Representatives). CMS should not cause payments to be delayed while software is in development; many managed care Medicare payors rely upon the PC pricer to accurately reimburse hospitals as well.

Wound Care Charge Process

There are six components to the wound care charge process:

1. Visit - evaluation and management levels
2. Nursing / Rehab Therapist procedures
3. Physician procedures
4. Diagnostic testing
5. Dermal tissue /Medications
6. Medical supplies / dressings

Visit – evaluation and management levels

E&M levels are divided into two types of patient, new and established. For facility fee billing, a new patient is one who has not been a patient at the facility within the last three years. There are five levels for both the new and established patient visits; for facility fee billing, the E/M level assignment is determined by hospital policy. PARA recommends facility fee E/M level assignment in keeping with time spent in delivering face-to-face care. Although the level of E/M is important for commercial billing, Medicare requires OPPS facilities to report only one code regardless of the visit level, G0463.

HCPCS / CPT®
99201 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

(continued)

Visit – evaluation and management levels (continued)

HCPCS / CPT®
99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
G0463 - hospital outpatient clinic visit for assessment and management of a patient

Modifier 25: In general, an E&M level should not be charged if the visit is scheduled to perform a procedure. If there is a separate and distinct reason for an E&M service which is beyond the routine patient interaction required to properly perform a procedure, such as a new diagnosis or condition or a new wound, a separate E&M may be billed. If an E&M is billed on the same date as a procedure, modifier "25 - separate and distinct" must be appended to the E&M code to qualify for payment.

Due to inappropriate use of modifier 25, the Health and Human Services Office of the Inspector General performed an investigation and issued a report of its findings. A link and an excerpt from the report are provided on the following page.

http://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

"Medicare payments for medical procedures include payments for certain evaluation and management (E/M) services that are necessary prior to the performance of a procedure. The Centers for Medicare & Medicaid Services (CMS) does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the separate E/M service. In calendar year 2002, Medicare allowed $1.96 billion for approximately 29 million claims using modifier 25."

Physician, Nursing and Rehab Therapists Procedures

There are five primary wound care procedures separately billable using HCPCS codes for physicians, nurses and rehab therapists:

97597 - Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598 - Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602 - Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session *[the word "larval" was added in 2017 CPT®.]*
97605 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607 - Negative pressure wound therapy, (eg, 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
97608 - Negative pressure wound therapy, (eg, 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

There are several additional procedures performed by the Wound Care Staff:

29445 - Application of rigid total contact leg cast
29580 - Strapping; Unna boot
29581 - Application of multi-layer venous wound compression system, below knee
29582 - Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed
29583 - Application of multi-layer compression system; upper arm and forearm
29584 - Application of multi-layer compression system; upper arm, forearm, hand, and fingers

Hyperbaric Oxygen Therapy (HBO) -- Both HBO codes a 99183 and G0277 are required to enable billing for both Medicare and non-Medicare patients; Medicare uses the G0277 code (which replaced the former Medicare code C1300), and commercial payers the 99183.

99183 - Physician attendance and supervision of hyperbaric oxygen therapy, per session
G0277 - Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval

There will be visits for which a procedure is not billable, and the patient is not seen by a Physician. An example of this type of visit would be a dressing change. In this instance a low-level E/M visit, such as 99211 (G0463 for Medicare) would be an appropriate charge level.

Documentation

All Nursing and Therapist procedures require a physician order, detail progress notes, and review and sign off of the progress notes by the attending Physician.

Physician Procedures

There are many procedures performed by Physicians on wound care patients in the hospital outpatient setting. The Physician bills procedures on a 1500 claim form with a site of service indicator “hospital outpatient”, the hospital bills on a UB04 claim form for the “technical” component of the procedure.

HCPCS / CPT®
11042 - Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043 - Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
11044 - Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
11045 - Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Physician Procedures - continued

11046 - Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11047 - Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Attention to CPT® code definitions for debridement is important. Please note:

- CPT® codes 11042, 11043, 11044, 11045, 11046, and 11047 are used to report surgical removal (debridement) of devitalized tissue from wounds. CPT® codes 11042, 11043, 11044, 11045, 11046, and 11047 are payable to physicians and qualified non-physician practitioners licensed by the state to perform the services.
- CPT® codes 97597 and 97598 are used to report selective (including sharp) debridement of devitalized tissue and are payable to physicians and qualified non-physician practitioners, licensed physical therapists and licensed occupational therapists.
- CPT® code 97602 is used to report non-selective debridement.
- Removal of non-tissue integrated fibrin exudates, crusts, biofilms or other materials from a wound without removal of tissue does not meet the definition of any debridement code and may not be reported as such.

Documentation of the debridement procedure in the 11042-11047 CPT® range should include the following components:

1. A statement affirming whether the debridement was excisional
2. The location, size, and condition of the wound
3. The depth to which the wound was debrided
4. The removal of devitalized or necrotic tissue
5. A list of the surgical instrumentation used

Diagnostic testing

Wound care patients receive a number of diagnostic tests, the tests which are commonly performed in the department are as follows:

HCPCS / CPT®
93922 - Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923 - Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924 - Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925 - Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926 - Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930 - Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931 - Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93965 - Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970 - Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971 - Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Medications

The majority of meds provided to a wound care patient in an outpatient setting will be considered a Medicare “self-administered drug” which is non-covered to the Medicare Program and must be billed to the patient. Medicare self-administered drugs are topical and oral drugs. Injections are usually billed to the Program as a covered benefit, but each MAC may publish a list of injectable drugs deemed “self-administered.”

Medical supplies

Medical supplies provided to a patient in an outpatient setting are billable to the program, there is very little reimbursement associated with the billing of supplies, and the supply cost is “packaged” into the reimbursement for the procedure.

Mechanically Powered Negative Pressure Wound Therapy

NPWT using Durable Medical Equipment (not disposable cartridge dressings) is billed with CPT®s 97605-97606:

Hcpcs / cpt®
97605 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606 - Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Two new CPT® codes were established in 2015 to address Medicare's G0456 and G0457 for services using disposable negative pressure wound therapy devices, which are not covered under the Medicare DME benefit but covered under Part B medical benefits. These two codes (97607 and 97608) provide payment to cover both the device and the procedure to apply it. On facility claims, the supply of the disposable NPWT cartridge is reported under revenue code 0272 (Sterile Supply) without a HCPCS. On a professional fee claim, no separate reporting for the supply is necessary or appropriate.

HCPCS / CPT®
97607 - Negative pressure wound therapy, (eg, 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
97608 - Negative pressure wound therapy, (eg, 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

An example of a disposable NPWT device:

Skin Substitutes -- Effective January 1, 2014, Medicare created 8 new C-Codes to be used by OPPS hospitals when billing low-cost skin substitute wound care procedures. The 8 new codes mirror the 15271 through 15278 codes:

HIGH COST SKIN SUBSTITUTE PROCEDURES APC 0328 – LEVEL III SKIN REPAIR	LOW COST SKIN SUBSTITUTE PROCEDURES APC 0327 – LEVEL II SKIN REPAIR
15271 - application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	**C5271** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272 - application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	**C5272** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15273 - application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	**C5273** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274 - application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; **each additional** 100 sq cm wound surface area, or part thereof, or **each additional** 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	**C5274** - Application of **low cost** skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; **each additional** 100 sq cm wound surface area, or part thereof, or **each additional** 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
15275 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	**C5275** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; **each additional** 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	**C5276** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; **each additional** 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15277 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	**C5277** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278 - application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; **each additional** 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	**C5278** - Application of **low cost** skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; **each additional** 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)

As of 4/1/17, skin substitutes have been assigned to high-cost or low-cost categories as follows:

HIGH COST SKIN SUBSTITUTE CATEGORY ASSIGNMENT (Bill with 1527X HCPCS Codes)			
HCPCS	**Description**	**HCPCS**	**Description**
C9363	Integra Meshed Bil Wound Mat	Q4138	BioDfence DryFlex, 1cm
Q4101	Apligraf	Q4140	Biodfence 1cm
Q4103	Oasis Burn Matrix	Q4141	Alloskin ac, 1 cm
Q4104	Integra BMWD	Q4143	Repriza, 1cm
Q4105	Integra DRT	Q4146	Tensix, 1cm
Q4106	Dermagraft	Q4147	Architect ecm px fx 1 sq cm
Q4107	Graftjacket	Q4148	Neox 1k, 1cm
Q4108	Integra Matrix	Q4150	Allowrap DS or Dry 1 sq cm
Q4110	Primatrix	Q4153	Dermavest 1 square cm
Q4116	Alloderm	Q4157	Revitalon 1 square cm
Q4120	Matristem Burn Matrix	Q4158	MariGen 1 square cm
Q4121	Theraskin	Q4159	Affinity 1 square cm
Q4122	Dermacell	Q4160	NuShield 1 square cm
Q4123	Alloskin	Q4161	Bio-Connekt per square cm
Q4126	Memoderm/derma/tranz/integup	Q4163	Amnion bio and woundex sq cm
Q4127	Talymed	Q4164	Helicoll, per square cm
Q4128	Flexhd/Allopatchhd/ matrixhd	Q4169	Artacent wound, per sq cm
Q4131	Epifix	Q4172*	Puraply or Puraply am, per sq cm
Q4132	Grafix core	Q4173	Palingen or Palingen Xplus, per sq cm
Q4133	Grafix prime	Q4175	Miroderm, per square cm
Q4137	Amnioexcel or Biodexcel, 1cm		

LOW COST SKIN SUBSTITUTE CATEGORY ASSIGNMENT (Bill with C527X HCPCS Codes)			
HCPCS	**Description**	**HCPCS**	**Description**
Q4100	Skin Subtitute, NOS	Q4151	AmnioBand, Guardian 1 sq cm
Q4102	Oasis wound matrix	Q4152	Dermapure 1 square cm
Q4111	Gammagraft	Q4154	Biovance 1 square cm
Q4115	Alloskin	Q4156	Neox 100 1 square cm
Q4117	Hyalomatrix	Q4162	Amnio bio and woundex flow
Q4119	Matristem Wound Matrix	Q4165	Keramatrix, per square cm
Q4124	Oasis Tri-layer Wound Matrix	Q4166	Cytal, per square centimeter
Q4129	Unite Biomatrix	Q4167	Truskin, per square cm
Q4134	HMatrix	Q4168	Amnioband, 1 mg
Q4135	Mediskin	Q4169	Artacent wound, per sq cm
Q4136	EZderm	Q4170	Cygnus, per square centimeter

*Pass-Through status paid separately; see next page for further information.

CMS included the cost of skin substitutes at $32 per unit for 25 units in the reimbursement for the high-cost procedure APC. When the 1527X code is billed with a skin substitute assigned pass-thru status G, which is paid separately, CMS will reduce the APC by $32 x 25 = $800, as explained in Transmittal 2845. A link and an excerpt from CMS Transmittal 2845 are provided below:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2845CP.pdf

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2845	**Date: December 27, 2013**
	Change Request 8572

SUBJECT: January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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f. Skin Substitute Procedure Edits

Effective January 1, 2014, the payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 7, Attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. Beginning January 1, 2014, CMS will implement an OPPS edit that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low cost skin substitute products in combination with one of the skin application procedures described by HCPCS code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278.

g. Offset from Payment for Pass-Through Skin Substitute Products

Section 1833(t)(6)(D)(i) of the Act requires that CMS deduct from pass-through payments for drugs or biologicals an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the drug or biological. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278. These skin application procedure codes are assigned to either APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair). CMS has

CMS Transmittal 2845 – continued

determined that it is able to identify a portion of the APC payment amount associated with the cost of skin substitute products in APC 0328 and APC 0329. This portion of the APC payment

represents the required deduction from pass-through payments for skin substitute products when they are billed with a skin substitute application procedure code in APC 0328 or APC 0329.

The offset amount for APC 0328 and APC 0329, along with the offsets for other APCs, is available under "Annual Policy Files" on the CMS OPPS Web site at http://www.cms.gov/HospitalOutpatientPPS/ ...

11. Changes to OPPS Pricer Logic

… i. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the "policy-packaged" portions of the CY 2014 payments for APC 0328 and APC 0329.

Excerpt from the 2016 OPPS Final Rule:

https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf

…To determine the actual APC offset amount for pass-through skin substitutes and pass-through stress agents that takes into consideration the otherwise applicable OPPS payment amount, we multiply the policy-packaged drug offset fraction by the APC payment amount for the procedure with which the pass-through skin substitute or pass-through stress agent is used and, accordingly, reduce the separate OPPS payment for the pass-through skin substitute or pass-through stress agent by this amount (78 FR 75019). In the CY 2016 OPPS/ASC proposed rule (80 FR 39274), for CY 2016, as we did in CY 2015, we proposed to continue to apply the skin substitute and stress agent offset policy to payment for pass-through skin substitutes and stress agents.

Procedural APCs with the CY 2016 portions of the APC payment amounts uniquely associated with the cost of devices and two types of non-pass-through drugs: "threshold packaged" drugs that are packaged under the packaging threshold and "policy-packaged" drugs that are always packaged. These portions will be used as the APC offset amounts to evaluate whether the cost of a device or type of drug in an application for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the device or type of drug.			Portion of APC Payment Associated with **Devices**, Including Implantable Biologicals		Portion of APC Payment Associated with **"Threshold Packaged" Drugs** (Drugs that May Be Packaged under the Packaging Threshold)		Portion of APC Payment Associated with **"Policy Packaged" Drugs** (Drugs that Are Always Packaged, *i.e.*, Diagnostic Radiopharmaceuticals, Contrast Agents, Skin Substitutes, and Stress Agents)	
APC	**APC Title**	**CY 2016 APC Payment Rate**	**Percent**	**Dollar Amount**	**Percent**	**Dollar Amount**	**Percent**	**Dollar Amount**
5051	Level 1 Skin Procedures	$117.83	0.02%	$0.02	1.00%	$1.18	0.06%	$0.07
5052	Level 2 Skin Procedures	$225.55	0.01%	$0.02	0.59%	$1.33	0.05%	$0.11
5053	Level 3 Skin Procedures	$428.67	0.15%	$0.64	0.66%	$2.83	9.15%	$39.22
5054	Level 4 Skin Procedures	$1,411.21	0.32%	$4.52	1.68%	$23.71	36.21%	$511.00
5055	Level 5 Skin Procedures	$2,137.49	1.19%	$25.44	4.96%	$106.02	6.52%	$139.36
5061	Hyperbaric Oxygen	$107.71	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00

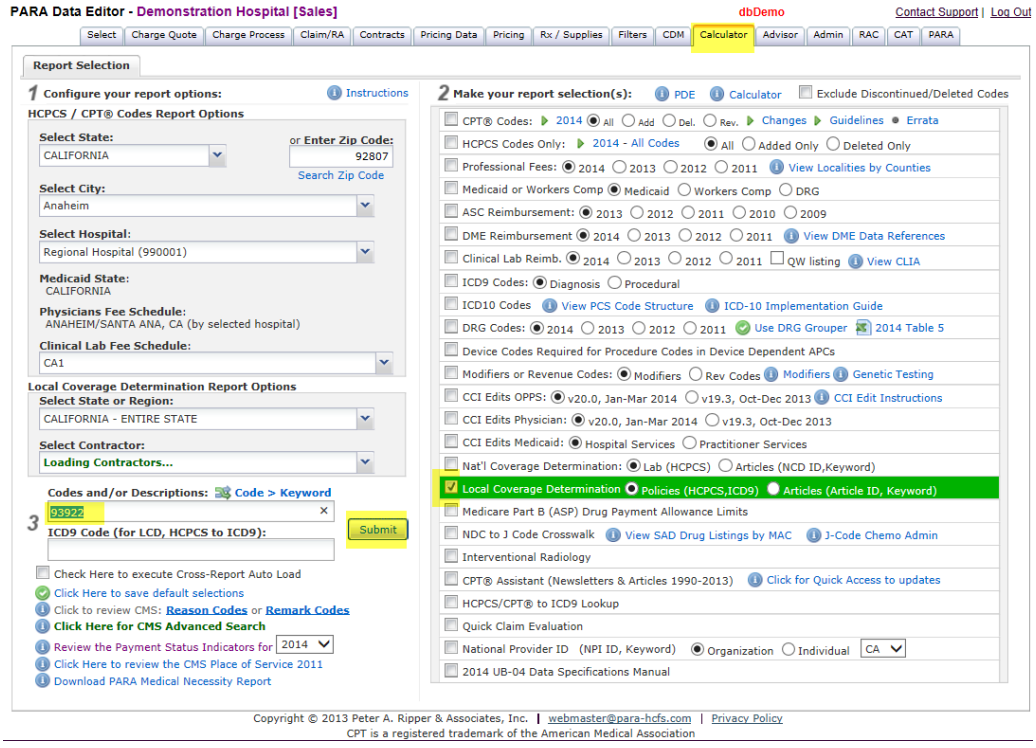
The following table illustrated the reimbursement adjustment for pass-through skin substitute use in which a 5 cm x 5 cm (25 sq. cm) patch of Puraply was used in the procedure:

HCPCS/CPT®	APC Status	APC	Units	Pass Thru Reimb	Payment
C9349 - Puraply, and Puraply Antimicrobial, any type, per square centimeter	G	1657 - Puraply, puraply antimic	25	109.18	2,729.50
15271 - Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	T	5054 - Level 4 Skin Procedures	1		1,407.42
Adjustment	APC 5054 reduction @ $511				-511.00

Total Reimbursement: **$3,625.92**

Local Coverage Determinations

Medicare Administrative Contractors (MACs) are authorized to establish payment policies which are published in "Local Coverage Determination" (LCD) documents. It is important to review LCDs published by the MAC in your jurisdiction to fully understand Medicare billing requirements and payment policies. LCDs change over time; they may be revised, retired, or introduced at any time. Links to current LCDs can be located on the **PARA Data Editor Calculator** Tab as highlighted below:



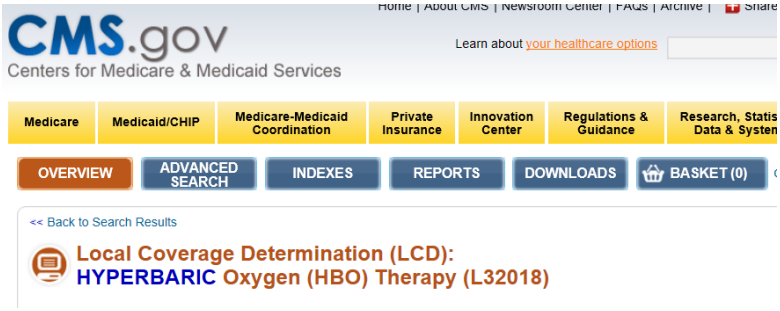
LCDs – Continued

There are many LCDs for wound care procedures including strapping, casting, Unna boot application, muscle testing, range of motion testing and physical therapy evaluation and procedure codes.

These LCDs are a "must read" for the Wound Care Manager. Links and excerpts from various LCDs appear on the following pages.

Hyperbaric LCD

There are a number of restrictive LCDs or hyperbaric therapy, please be sure to check the **PARA Data Editor** and advise your Wound Care Department Managers on the specifics for your facility.



Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

For the purposes of coverage under Medicare, HBO therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Medicare reimbursement will be limited to therapy that is administered in a chamber (including the one-man unit).

Medicare will cover HBO therapy in the setting of a hospital, either inpatient or outpatient. This is predicated upon the potential need for ICU level services and/or Advanced Cardiac Life Support (ACLS) should a complication occur in the delivery of this treatment. It is anticipated that in the hospital setting, the process of appropriate credentialing will be determined by local professional credentialing authorities.

HBO may be considered medically reasonable and necessary when performed in the non-hospital affiliated setting when all of the following criteria are met:

1. Direct supervision is provided by a physician certified in Undersea and Hyperbaric Medicine by the American Board of Emergency Medicine (ABEM) or American Board of Preventive Medicine (ABPM) or the American Osteopathic Conjoint Committee of Underseas and Hyperbaric Medicine (AOCUHM); or who has successfully completed a minimum 40 hour in-person accredited training program such as one approved by the American College of Hyperbaric Medicine or the Underseas and Hyperbaric Medical Society and has supervised at least 300 HBO treatments.
    - In the office setting, "direct supervision" per 42 CFR 410.26(a)(2) and 410.32(b)(3)(ii) *means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.*
    - In the hospital outpatient setting, "direct supervision" per 42 CFR 410.27(f) *means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure.*
    - Podiatric physicians may supervise HBO therapy if the service is within their state scope of practice and if the body area or condition being treated by the HBO therapy is also within the podiatric scope of practice.
    - Qualified non-physician practitioners (NPPs) may supervise HBO therapy if the service is within their state scope of practice, if their required supervision or collaborative agreement is with a physician qualified to provide HBO therapy services, and if the NPP meets the educational requirements identified in this LCD.
2. The supervising provider must be ACLS trained and certified.
3. If the supervising provider response time to the chamber may be expected to exceed five minutes, the personnel that is chamber side during HBO therapy must be ACLS trained and certified.

HBO therapy performed in a hospital outpatient department is an "incident to" service and requires physician supervision. This requirement is presumed to be met when services are performed on the hospital premises (i.e., certified as part of the hospital and part of the hospital campus); however, in all locations, it is recommended that the physician be present during the ascent and descent portions of the HBO treatment.

"Immediately available" in the context of HBO therapy performed in a on-campus provider-based department or in an off-campus hospital site is defined as the supervising physician or qualified NPP present in the office suite or a maximum response time to the chamber of five minutes. The supervising physician or qualified NPP must be present in the office suite for HBO therapy performed in a non-hospital setting.

NOTE: The Office of the Inspector General (OIG) links the quality of care to the physical presence of the physician during the entire treatment for the purpose of managing the patient's overall care, as identified in the October 2000 report, 'Hyperbaric Oxygen Therapy, Its Use and Appropriateness.'

The MAC for Ohio and Kentucky, CGS, applies LCD 34045 "Non-Invasive VASCULAR Studies"; a link and an excerpt are provided below:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34045&ContrTypeId=9&ver=8&ContrNum=15102&ContrId=228&ContrVer=2&SearchType=Advanced&CoverageSelection=Local&ArticleType=Ed|Key|SAD|FAQ&PolicyType=Both&s=---&Cntrctr=228&ICD=&CptHcpcsCode93922&kq=true&bc=IAAAACAAAAAA&

INDICATIONS AND LIMITATIONS:

General Indications:

Non-invasive vascular studies are considered medically necessary if the ordering physician has reasonable expectation that their outcomes will potentially impact the clinical management of the patient. Services are deemed medically necessary when the following conditions are met:

- Significant signs/symptoms of arterial or venous disease are present;
- The information is necessary for appropriate medical and/or surgical management; and/or
- The test is not redundant of other diagnostic procedures that must be performed.

In general, non-invasive studies of the arterial system are utilized when invasive correction is contemplated. It is the responsibility of the physician/provider to ensure the medical necessity of procedures and documentation of such in the medical record.

Credentialing and Accreditation Standards

The accuracy of non-invasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and interpreter. Consequently, the physician performing and/or interpreting the study must be capable of demonstrating documented training and experience and maintain any applicable documentation. A vascular diagnostic study may be personally performed by a physician or a technologist.

The GAO Report to Congressional Committees entitled Medicare Ultrasound Procedures. Consideration of Payment Reforms and Technician Qualifications Requirements states that "Findings from several peer-reviewed studies, the Medicare Payment Advisory Commission, and ultrasound-related professional organizations support requiring that sonographers either have credentials or operate in facilities that are accredited, where specific quality standards apply. In some localities and practice settings, CMS or its contractors have required that sonographers either be credentialed or work in an accredited facility." (GAO-07-734)

For areas under CGS Administrators, LLC jurisdiction the requirements will be effective for all providers 30 April 2011:

- All non-invasive vascular diagnostic studies must be performed under at least one of the following settings: (1) performed by a physician who is competent in diagnostic vascular studies or under the general supervision of physicians who have demonstrated minimum entry level competency by being credentialed in vascular technology, or (2) performed by a technician who is certified in vascular technology, or (3) performed in facilities with laboratories accredited in vascular technology.
- Examples of appropriate personnel certification include, but are not limited to the Registered Physician in Vascular Interpretation (RPVI), Registered Vascular Technologist (RVT), the Registered Cardiovascular Technologist (RCVT), Registered Vascular Specialist (RVS), and the American Registry of Radiologic Technologists (ARRT) credentials in vascular sonography. Appropriate laboratory accreditation includes the American College of Radiology (ACR) Vascular Ultrasound Program, and the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).
- Additionally, transcutaneous oxygen tension measurements may be performed by individuals possessing the following credentials obtained from the National Board of Diving and Hyperbaric Medicine Technology (NBDHMT): Certified Hyperbaric Technologist (CHT), or Certified Hyperbaric Registered Nurse (CHRN).

A number of MACs offer broad Local Coverage Determinations for wound care. For example, LCD 34587 for Wound care became effective in 2015 for Iowa, Kansas, Missouri, Nebraska, Indiana, and Michigan. Similar LCDs exist for other states. A large portion of the LCD is provided for review on the following pages.

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34587&ver=22&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Kentucky&KeyWord=Wound&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&

Local Coverage Determination (LCD): Wound Care (L34587)

Coverage Indications, Limitations, and/or Medical Necessity

For the purposes of this LCD, wound care is defined as care of wounds that are refractory to healing or have complicated healing cycles either because of the nature of the wound itself or because of complicating metabolic and/or physiological factors. This definition excludes management of acute wounds, the care of wounds that normally heal by primary intention such as clean, incised traumatic wounds, surgical wounds that are closed primarily and other postoperative wound care not separately payable during the surgical global period.

This policy does not address metabolically active human skin equivalent/substitute dressings, burns, skin cancer or hyperbaric oxygen therapy.

WOUND CARE should employ comprehensive wound management including appropriate control of complicating factors such as unrelieved pressure, infection, vascular and/or uncontrolled metabolic derangement, and/or nutritional deficiency in addition to appropriate debridement.

Medicare coverage for WOUND CARE on a continuing basis for a particular wound in a patient requires documentation in the patient's record that the wound is improving in response to the WOUND CARE being provided. It is not medically reasonable or necessary to continue a given type of WOUND CARE if evidence of wound improvement cannot be shown.

Evidence of improvement includes measurable changes (decreases) of some of the following:

Drainage (color, amount, consistency)

Inflammation

Swelling

Pain

Wound dimensions (diameter, depth, tunneling)

Necrotic tissue/slough

Such evidence must be documented with each date of service provided. A wound that shows no improvement after 30 days requires a new approach which may include physician reassessment of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment.

Debridement is defined as the removal of foreign material and/or devitalized or contaminated tissue from or adjacent to a traumatic or infected wound until surrounding healthy tissue is exposed. This LCD applies to debridement of localized areas such as wounds and ulcers. It does not apply to the removal of extensive eczematous or infected skin.

Debridements of the wound(s), if indicated, must be performed judiciously and at appropriate intervals. Medicare expects that with appropriate care, wound volume or surface dimension

should decrease by at least 10 percent per month or wounds will demonstrate margin advancement of no less than 1 mm/week. Medicare expects the wound-care treatment plan to be modified in the event that appropriate healing is not achieved.

- Surgical debridement is excision or wide resection of all dead or devitalized tissue, possibly including excision of the viable wound margin. This is usually carried out in the operating theatre under anesthesia by a surgeon. It is frequently used for deep tissue infection, drainage of abscess or involved tendon sheath, or debridement of bone.
- Sharp debridement is the removal of dead or foreign material just above the level of viable tissue, and is performed in an office setting or at the patient's beside with or without the use of local anesthesia. Sharp debridement is less aggressive than surgical debridement but has the advantage of rapidly improving the healing conditions in the ulcer. These typically are the services of recurrent, superficial or repeated wound care.
- Blunt debridement is the removal of necrotic tissue by cleansing, scraping, chemical application or wet to dry dressing technique. It may also involve the cleaning and dressing of small or superficial lesions. Generally, this is not a skilled service and does not require the skills of a therapist, nurse, wound nurse, or wound continence ostomy nurse (WOCN).
- Enzymatic Debridement is debridement with topical enzymes used when the necrotic substances to be removed from a wound are protein, fiber and collagen. The manufacturers' product insert contains indications, contraindications, precautions, dosage and administration guidelines. It would be the clinician's responsibility to comply with those guidelines.

At least ONE of the following conditions must be present and documented:

- Pressure ulcers, Stage III or IV,
- Venous or arterial insufficiency ulcers,
- Dehiscenced wounds,
- Wounds with exposed hardware or bone,
- Neuropathic ulcers,
- Complications of surgically-created or traumatic wound where accelerated granulation therapy is necessary which cannot be achieved by other available topical wound treatment.

Selective debridement refers to the removal of specific, targeted areas of devitalized or necrotic tissue from a wound along the margin of viable tissue. Occasional bleeding and pain may occur. The routine application of a topical or local anesthetic does not elevate active wound care management to surgical debridement. Selective debridement includes selective removal of necrotic tissue by sharp dissection including scissors, scalpel, and forceps; and selective removal of necrotic tissue by high-pressure water jet. Selective debridement should only be done under the specific order of a physician.

High Pressure Water Jet / Pulsed Lavage: (non-immersion hydrotherapy) is an irrigation device, with or without pulsation used to provide a water jet to administer a shearing effect to loosen debris, within a wound. Some electric pulsatile irrigation devices include suction to remove debris from the wound after irrigation.

Debridement is used in the management and treatment of wounds or ulcers of the skin and underlying tissue. Providers should select a debridement method most appropriate to the type of wound, the amount of devitalized tissue, and the condition of the patient, the setting, and the provider's experience.

Debridements of the wound(s), if indicated, must be performed judiciously and at appropriate intervals. With the appropriate care, wound volume or surface dimension should decrease, once the size and depth of involvement and the extent of the undermining has been established. Interim outcomes should be established for the wound. These short-term goals help the clinician recognize wound improvement and serve to confirm the patient's wound-healing response. Medicare expects the wound-care treatment plan to be modified in the event that appropriate healing is not achieved.

The original debridements are typically true surgical debridements. Repeated debridements are not the same service as the original debridement service. However, once the initial debridement of muscle and/or bone has been performed, there typically is no true necrotic muscle or bone remaining. Subsequent surgical debridement of muscle or bone is usually not necessary. If the medical record demonstrates complicating factors are present that contribute to further necrosis of muscle or bone, then subsequent staged surgical debridement of muscle and/or bone may be deemed necessary. The medical records should indicate the complicating factor(s) and the medical management used to control these complications. Staged debridement of muscle and/or bone greater than two additional debridements, should raise the question of whether the complicating factors are controlled adequately. Further debridement of muscle and/or bone may not be justified without adequate control of the underlying condition(s) leading to the complicating factors (i.e. infection, abscess, vascular insufficiency, nutritional compromise, etc.).

Just because there is a Stage IV pressure ulcer, additional debridements are not necessarily bone and/or muscle debridements. The issue in billing for debridement services is not the stage of the wound; it is what procedure is actually being performed. A Stage III or Stage IV pressure ulcer should be billed with the CPT code that describes the service rendered.

Electrical Stimulation and Electromagnetic Therapy

Care of chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers through use of Electrical Stimulation (ES) or Electromagnetic Therapy (ET) is covered under the limitations detailed in the CMS Pub 100- 03 National Coverage Determination (NCD) Manual, Chapter 1 – Coverage Determination, Part 4, Section 270.1 – Electrical Stimulation (ES) and Electromagnetic Therapy for Treatment of Wounds. See the CMS policy for full text.

With appropriate management, it is expected that, in most cases, a wound will reach a state at which its care should be performed primarily by the patient and/or the patient's caregiver with periodic physician assessment and supervision.

The following services are not considered debridement:

- Mechanical Debridement: Wet-to-moist dressings may be used with wounds that have a high percentage of necrotic tissue. Hydrotherapy (immersion without jets) and wound irrigation (non-pulsated) are also forms of mechanical debridement used to remove necrotic tissue. They also should be used cautiously as maceration of surrounding tissue may hinder healing.

Documentation must support the use of skilled personnel in order to be considered for coverage. While mechanical debridement is a valuable technique for healing ulcers, it does not qualify as debridement services.

- Removal of necrotic tissue by cleansing, scraping (other than by a scalpel or a curette), chemical application, and wet-to-dry dressing.
- Scraping the base of the wound bed to induce bleeding, following the removal of devitalized tissue, is not considered to be a separately billable service.
- Washing bacterial or fungal debris from lesions.
- Removal of secretions and coagulation serum from normal skin surrounding an ulcer.
- Dressing of small or superficial lesions.
- Paring or cutting of corns or non-plantar calluses. Skin breakdown under a dorsal corn that begins to heal when the corn is removed and the shoe pressure eliminated may be a small ulcer but generally does not require true debridement unless the breakdown extends significantly into the subcutaneous tissue.
- Incision and drainage of abscess including paronychia, trimming or debridement of mycotic nails, avulsion of nail plates, acne surgery, destruction of warts, or burn debridement. Providers should report these procedures, when they represent covered, reasonable and necessary services, using appropriate CPT or HCPCS codes.
- Removing a collar of callus (hyperkeratotic tissue) around an ulcer is not debridement of skin or necrotic tissue and should not be billed as debridement unless additional partial full skin thickness tissue directly deep to the callus is removed as well.

Negative Pressure Wound Therapy:

Negative Pressure Wound Therapy (NPWT) involves the application of controlled or intermittent negative pressure to a properly dressed wound cavity. Suction (negative pressure) is applied under airtight wound dressings to promote the healing of open wounds resistant to prior treatments.

Low Frequency, Non-Contact, Non-thermal Ultrasound:

Low frequency, non-contact, non-thermal ultrasound is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. This type of therapy is included in the payment for the treatment of the same wound with other active wound care management or wound debridement. Low frequency, non-contact, non-thermal ultrasound treatments would be separately billable if other active wound management and/or wound debridement is not performed.

Non-Covered Modalities:

The following Non-Selective Debridement Techniques are not separately billable:

- Chemical: necrotic tissue is digested by exogenous proteases in the wound (Enzymes, hypertonic saline). Debridement with topical enzymes is used when the necrotic substances to be removed from a wound are protein, fiber and collagen.

- Whirlpool: Whirlpool is considered for coverage if medically necessary for the healing of the wound. Generally, whirlpool treatments do not require the skills of a therapist to perform. The skills of a therapist may be required to perform an accurate assessment of the patient and the wound to assure the medial necessity of the whirlpool for the specific wound type.

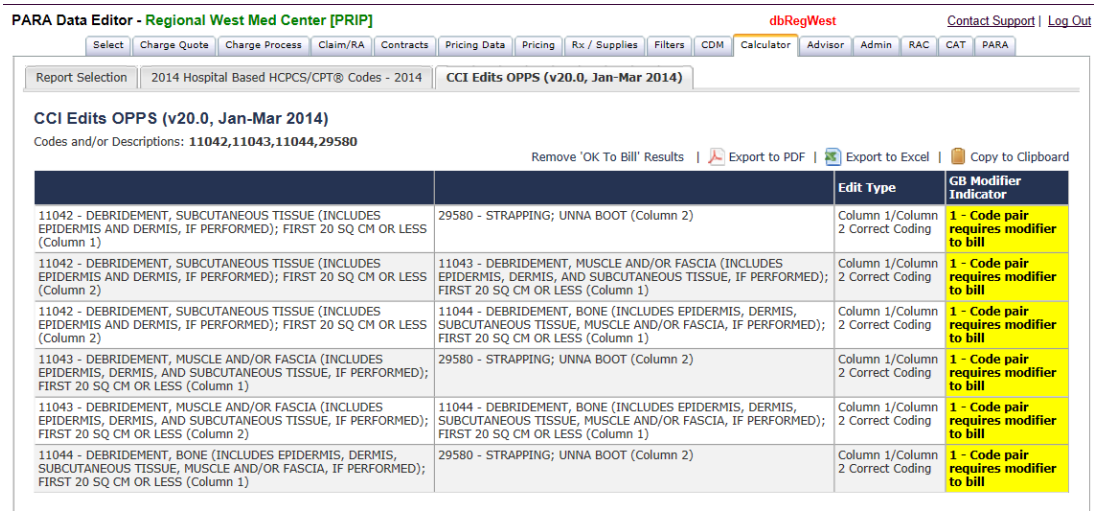
  Documentation must support the use of skilled personnel in order to be considered for coverage. The skills, knowledge and judgment of a qualified therapist might be required when the patient's condition is complicated by circulatory deficiency, areas of desensitization, complex open wounds, and fractures. Immersion in the whirlpool to facilitate removal of a dressing would not be considered a skilled treatment modality and would not be billable.
- Massage: Massage has not been proven to be effective in wound care and will not be considered for coverage.
- Ultra-sound deep thermal modality: The effectiveness of this modality has not been proven in wound care; and therefore will not be considered for coverage.
- Infrared: CMS Pub100-03 Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 270.6 – Infrared Therapy Devices.
- Noncontact Normothermic Wound Therapy (NNWT): CMS Pub 100-03 Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 270.2 – Noncontact Normothermic Wound Therapy (NNWT).
- Blood-Derived Products for Chronic Non-Healing Wounds: CMS Pub 100-03 Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 270.3 - Blood-Derived Products for Chronic Non-Healing Wounds.
- Dressing changes not separately payable.
- Phototherapy-ultraviolet used to promote healing of skin disorders will not be considered for coverage for decubitus ulcers. The safety and effectiveness has not been established. CMS Pub
- 100-03 Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 270.4 – Treatment of Decubitus Ulcers.
- Trimming of callous or fibrinous material from the margins of an ulcer or from feet with no ulcer present is not considered debridement by this Contractor and would not be considered for coverage.
- Nutritional counseling.
- Documentation time
- Administrative tasks

Maintenance wound care is not covered as debridement services.

Wound Care Coding Scenarios

Scenario #1: An established patient presents with an open wound along an incision in the right lower extremity, and an open wound of the left lower extremity. Our usual weekly visit services include debridement of devitalized tissue to both sites, then application of Unna boots to both lower extremities. Usually we would charge one selective debridement and one Unna boot.

Answer: *Due to Correct Coding Initiative edits, an Unna Boot and a debridement cannot be billed together for treatment of the same area.*


PARA Data Editor - Regional West Med Center [PRIP] dbRegWest Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Report Selection | 2014 Hospital Based HCPCS/CPT® Codes - 2014 | CCI Edits OPPS (v20.0, Jan-Mar 2014)

CCI Edits OPPS (v20.0, Jan-Mar 2014)

Codes and/or Descriptions: 11042,11043,11044,29580

Remove 'OK To Bill' Results | Export to PDF | Export to Excel | Copy to Clipboard

		Edit Type	GB Modifier Indicator
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 2)	11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS (Column 1)	29580 - STRAPPING; UNNA BOOT (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill

Since both debridement and an Unna boot cannot be charged together for the same leg, charge the highest-paying completed service per leg.

HCPCS/CPT®	Status	APC	APC Payment
11042 - DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS	T	5052 - Level 2 Skin Procedures	$225.55
11043 - DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS	T	5053 - Level 3 Skin Procedures	$428.67
11044 - DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); FIRST 20 SQ CM OR LESS	T	5073 - Level 3 Excision / Biopsy / Incision and Drainage	$941.98
29580 - STRAPPING; UNNA BOOT	S	5101 - Level 1 Strapping and Cast Application	$119.24

If Unna Boot 29580 is reported for both legs, code one line of one unit each with the modifier 50 appended.

Scenario #2: Patient presents with five wounds and sutures on the right lower extremity. The physician examines the patient and orders sutures to be removed, continue the Unna boots. Can we charge an E/M level 3 (follow-up, 2-5 wounds, suture removal =60 points) AND for 2 Unna boot applications?

> ***Answer**: Since the scenarios imply an established patient ("continue the Unna boots"), no separate E/M code should be billed. Since the examination involved removing the Unna boots, examining the wounds, removing sutures, and re-applying Unna boots, the evaluation and management provided is covered within the reimbursement for the Unna boot procedure alone. The removal of sutures is insignificant and does not justify a separate E/M.*
>
> *If this had been a new patient, the first-time evaluation by the physician coupled with suture removal could sufficiently support billing a separate and distinct E/M service. In that case, modifier -25 should be appended to the E/M.*

Scenario 3: We have a new patient come in for an initial established patient visit, her family physician referred her. The wound clinic RN assesses and calls wound care physician for orders. The wound care physician doesn't see the patient until a follow-up appointment at a later date. The patient is a Hoyer lift, therefore additional staff is required, and patient is unable to assist with undressing or dressing. Culture was obtained, pulses assessed. Care takes well over 1 hour, no procedure was performed.

Since the wound physician did not see the patient, are we limited to charge only an E/M level 99211, or can we charge a higher level such as 99212, 99213, 99214, or 99215?

> ***Answer**: You may charge a higher level E/M if your facility point-based system for assigning the level supports it. The fact that the ordering physician has not personally examined the patient at the time of initial assessment does not affect the facility E/M code. In 2013, CPT® Evaluation and Management code descriptions were modified to remove physician-only language:*

Appendix B—Summary of Additions, Deletions, and Revisions

▲ **99213** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **An expanded problem focused history;**
- **An expanded problem focused examination;**
- **Medical decision making of low complexity.**

Counseling and coordination of care with other physicians, other ~~providers~~qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. ~~Physicians typically spend~~Typically, 15 minutes are spent face-to-face with the patient and/or family.

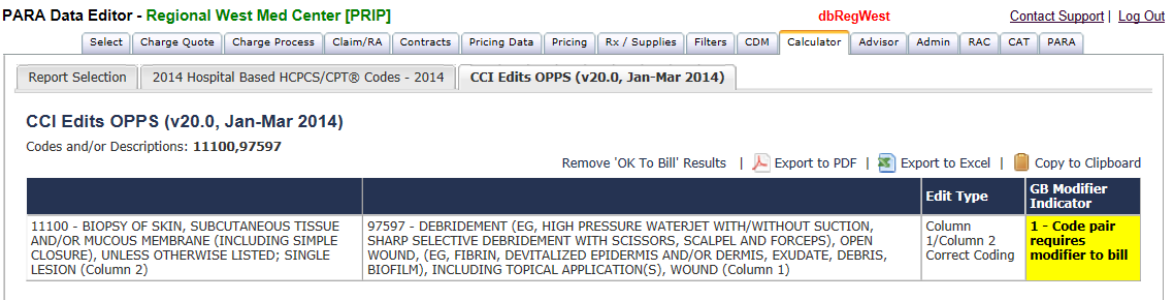
> *Code the level of the E/M according to the facility's E/M level assignment criteria. Note that effective 1/1/2014, Medicare requires G0463 in lieu of 99201-99215.*

Scenario 4: We have been seeing a patient for debridement of lower extremity ulcers and application of Unna boots bilaterally. During the visit, the patient is measured for a pressure garment. The patient requires assistance in dressing, and additional staff to help transfer the patient to and from a wheelchair is required. Can we charge a level 3 E/M and the procedure code?

> ***Answer:*** *No; although additional resources were used to dress and move the patient, an E/M may not be billed because the services were not "separate and distinct" from the billable procedures.*

Scenario 5: We have been seeing a patient who presents with no new signs or symptoms; we perform debridement to wounds on the lower extremities and apply Unna boots bilaterally. Additional staff is required due to the emotional state of the patient. During the visit, the physician examines the patient and decides to do a puncture biopsy. Can we charge a level 2 E/M (99212) and the puncture biopsy as well as the debridement?

> ***Answer****: For an established patient, you may charge the E/M for the additional resources above and beyond an ordinary patient encounter only if the additional resources (such as staff time) are documented as separate and distinct from the billable procedures. Nursing care addressing the emotional state of the patient may qualify if the documentation sufficiently demonstrates that the additional resources required were more than incidental in nature.*
>
> *Among the three procedures described (debridement, puncture biopsy, unna boot), only the debridement should be billed. CCI edits do not permit a puncture biopsy performed on the same site as the debridement to be separately billed. A modifier indicating the biopsy was performed on a site other than that of the debridement is required to bill 97597 with 11000.*



Here is the pertinent excerpt from the 2014 National Correct Coding Initiative manual:

> "The HCPCS/CPT codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter. CPT codes 11100-11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately. CPT codes 11100-11101 may be separately reportable with lesion removal HCPCS/CPT codes if the biopsy is performed on a different lesion than the removal procedure."

Scenario 5 - continued

Additionally, according to Medicare's 2014 Correct Coding Initiative Manual, the Unna boot application (HCPCS 29580) should not be reported separately when debridement is performed:

"…Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Additionally casting/splinting/strapping CPT codes should not be reported for application of a dressing after a therapeutic procedure. Several examples follow:

1) If a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider should not report CPT codes such as 29515, 29540, or 29580 for that anatomic area;
2) A provider should not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20615);
3) Debridement CPT codes (e.g., 11042-11044, 97597) and grafting CPT codes (e.g., 15040-15776) should not be reported with a casting/splinting/strapping CPT code (e.g., 29445, 29580, 29581) for the same anatomic area."

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Compliance: HIM / Business Office assigned codes and modifiers

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Healthcare Financial Services

The demand for meaningful information is growing because of the increased number of healthcare consumers who are faced with having to pay a larger share of their medical bills. Consumer advocates, employers and health plans are also pushing for greater reporting of prices for healthcare services.

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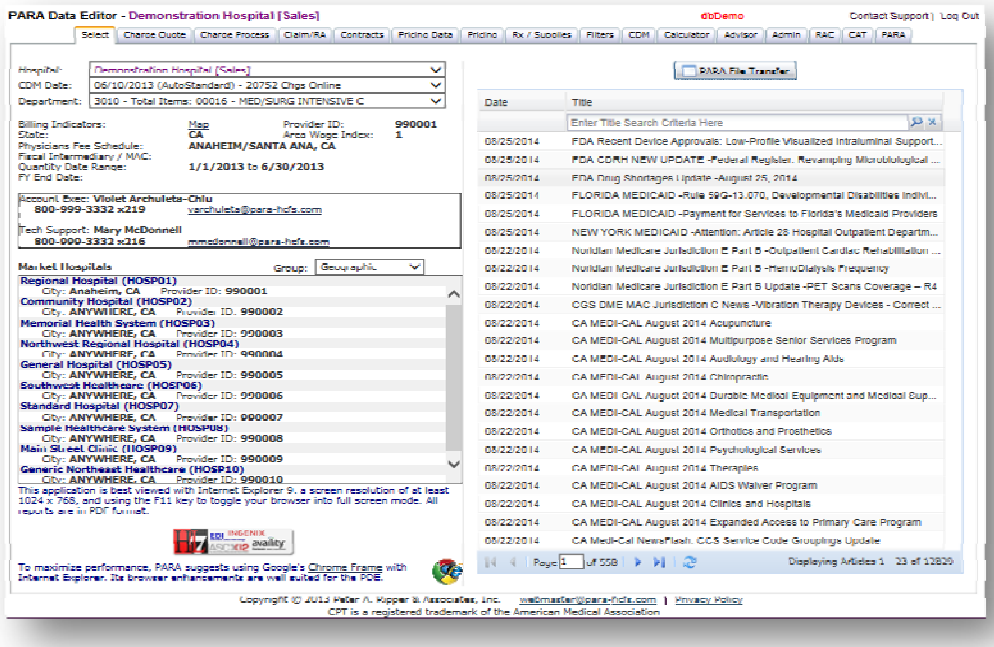
- **PARA Out-of-Pocket Estimates Widget** – To promote price transparency on your website, improve upfront collections, attract a good payer mix, and enhance employer relationships



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