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

<u>Visit – evaluation and management levels</u>

E&M levels are divided into two sections, new and established; a new patient is one who has not been a patient at the facility within the last three years, this is checked by making a query of the patient's name into the HIM system.

There are five levels for both the new and established patient visits; the levels are determined by the amount of direct time a hospital staff spends with the patient, the CPT/HCPCS code refers to a Physician.

Visit – evaluation and management levels

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 providers 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. Physicians typically spend 10 minutes 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 providers 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 20 minutes face-to-face with the patient and/or family.

99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers 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 severity. Physicians typically spend 30 minutes 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 providers 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. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

<u>Visit – evaluation and management levels (continued)</u>

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 providers 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. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. 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 providers 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. Physicians typically spend 10 minutes 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 providers 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 15 minutes 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 providers 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. Physicians typically spend 25 minutes 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 providers 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. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

A E&M level should not be charged if the visit is scheduled to perform a procedure, the E&M requires a modifier "25 - separate and distinct" if the visit and procedure are to be charged on the same encounter. (Reference the OIG position paper on the use of Modifier 25 at the end of this paper.)

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), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

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

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
- 99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session
- C1300 HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER, PER 30 MINUTE INTERVAL

The two HBO codes are required for Medicare and non-Medicare patients; Medicare uses the C1300 code, commercial payers the 99183.

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 99211 visit code would be charged.

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.

- **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)
- **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)
- **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
- **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)
- **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
- **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)
- **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
- **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)
- **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
- **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)

Diagnostic testing

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

- **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

Dermal Tissue

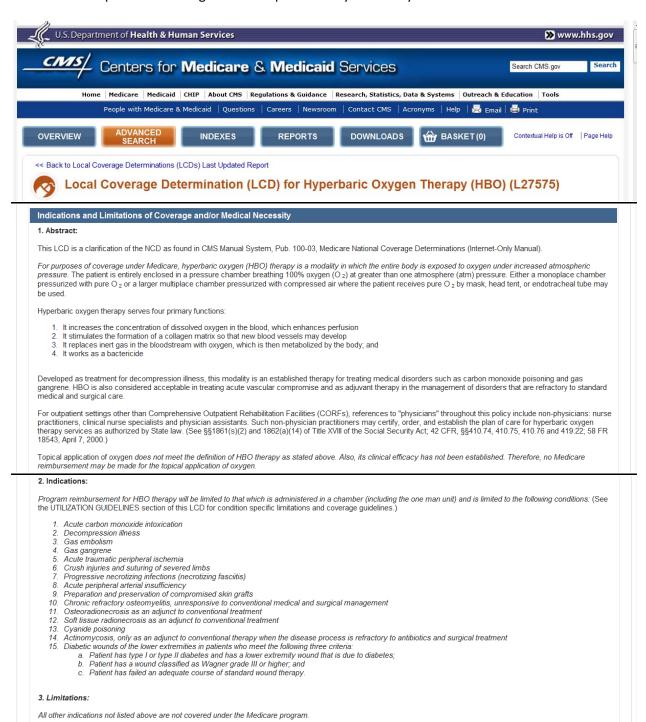
There are several different types of dermal tissue; the important billing concern is to bill the tissue by square centimeter, and to follow the rules on "wasted" tissue.

The wasted tissue is to be billed using a HCPCS code and the JW modifier "drug amount discarded, not administered".

Q4100 - SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED
Q4101 - APLIGRAF, PER SQUARE CENTIMETER
Q4102 - OASIS WOUND MATRIX, PER SQUARE CENTIMETER
Q4103 - OASIS BURN MATRIX, PER SQUARE CENTIMETER
Q4104 - INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER
Q4105 - INTEGRA DERMAL REGENERATION TEMPLATE (DRT), PER SQUARE CENTIMETER
Q4106 - DERMAGRAFT, PER SQUARE CENTIMETER
Q4107 - GRAFTJACKET, PER SQUARE CENTIMETER
Q4108 - INTEGRA MATRIX, PER SQUARE CENTIMETER
Q4110 - PRIMATRIX, PER SQUARE CENTIMETER
Q4111 - GAMMAGRAFT, PER SQUARE CENTIMETER
Q4112 - CYMETRA, INJECTABLE, 1CC
Q4113 - GRAFTJACKET XPRESS, INJECTABLE, 1CC
Q4114 - INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC
Q4115 - ALLOSKIN, PER SQUARE CENTIMETER
Q4116 - ALLODERM, PER SQUARE CENTIMETER
Q4118 - MATRISTEM MICROMATRIX, 1 MG
Q4121 - THERASKIN, PER SQUARE CENTIMETER
C9358 - DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, FETAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS
C9360 - DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS
C9367 - SKIN SUBSTITUTE, ENDOFORM DERMAL TEMPLATE, PER SQUARE CENTIMETER

Hyperbaric LCD

There are a number of restrictive LCD's for hyperbaric therapy, please be sure to check and advise your Wound Care Department Managers on the specifics for your facility.

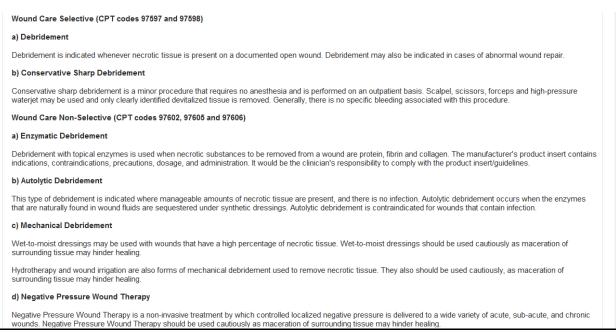


Wound Care LCD

There are also many LCD's for wound care procedures including strapping, casting, unna boot application, muscle testing, range of motion testing and physical therapy evaluation and procedure codes.

This LCD is a "must read" for the Wound Care Manager.





Muscle testing, manual (CPT Codes 95831-95834)

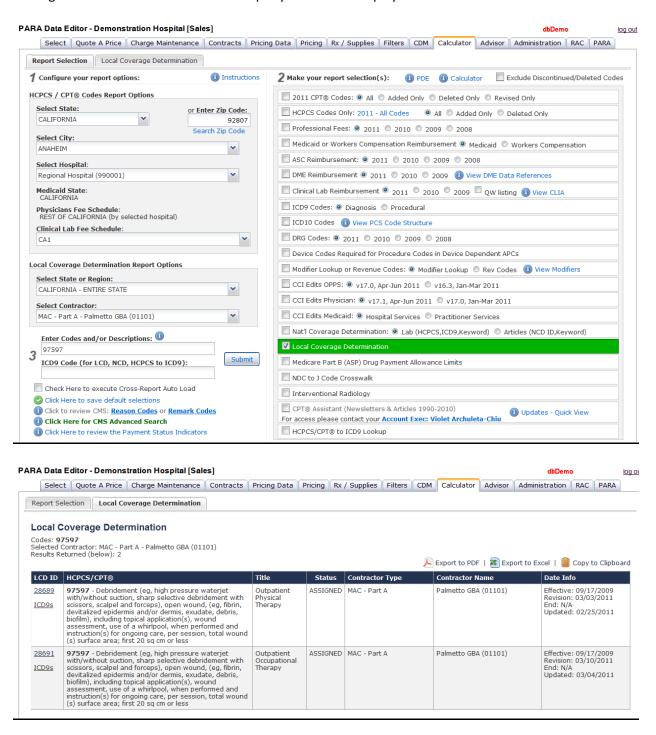
The series of codes 95831-95834 are intended to report manual test of muscles or muscle groups for strength based on grading scales

Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk (CPT code 95831)

To use this code for extremity manual muscle testing, every muscle of at least one extremity would need to be tested, with documentation of why such a thorough assessment was warranted.

PARA Calculator

All LCD's and NCD's can be located using the PDE Calculator, be sure to have your Contractor selected, and query the code. If your Contractor does not have a LCD on file for your region and there is a LCD for the region from another Contractor the query results will display the links.



Office of the Inspector General – Modifier 25 – rules and documentation requirements

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OBJECTIVE

To determine the extent to which use of modifier 25 meets Medicare program requirements.

BACKGROUND

Evaluation and management (E/M) services that are necessary for the performance of a medical procedure (for example, assessing the site/condition of the problem area, explaining the procedure, and obtaining informed consent) are included in Medicare payments for the 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, the provider may attach modifier 25 to the E/M service claim² to facilitate billing and to allow separate payment for the E/M service.³ In calendar year 2002, Medicare allowed \$1.96 billion for approximately 29 million services billed using modifier 25.

Medications

The majority of meds provided to a wound care patient in an outpatient setting will be considered a Medicare "self admin drug" which is non-covered to the Medicare Program and must be billed to the patient.

Medicare self admin drugs are topical and oral drugs, injections are usually billed to the Program as a covered benefit.

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.

General notes

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.