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LCD L27547 - Wound CarePrint

Contractor Information

Contractor Name:

Novitas Solutions, Inc.

Contractor Number(s):

12501, 12502, 12101, 12102, 12201, 12202, 12301, 12302, 12401, 12402, 12901

Contractor Type:

MAC Part A & B

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LCD Information

Document Information

LCD ID Number

L27547

LCD Title

Wound Care

Contractor's Determination Number

L27547

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Primary Geographic Jurisdiction

Pennsylvania, Maryland, Delaware, District of Columbia, New Jersey

Oversight Region

Central Office

Original Determination Effective Date

For services performed on or after 07/11/2008

Original Determination Ending Date

N/A

Revision Effective Date

For services performed on or after 01/01/2013

Revision Ending Date

N/A

CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

CMS Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Section 220

CMS Internet-Only Manual (IOM) Publication 100-03, Chapter 1, Section 270.2 discusses the NCD for Noncontact Normothermic Wound Therapy

Indications and Limitations of Coverage 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.

This policy addresses the care of wounds, including, but not limited to ulcers, pressure ulcers, open surgical sites, fistulas, tube sites and tumor erosion sites when the skills of a licensed therapist, qualified wound care nurse, nurse or physician/physician extender are required to safely and effectively provide the care necessary for their treatment.

This LCD does not address specific wound care procedures described by NCD's and other items such as:

Hyperbaric oxygen therapy

Electrical stimulation and electromagnetic therapy

Noncontact normothermic wound therapy

Treatment of burns

Initial physical therapy or occupational therapy evaluations

Wound healing involves several factors and is influenced by the severity of the injury. Partial thickness wounds penetrate the epidermis and involve the dermis. A full thickness wound involves the epidermis and dermis and may include subcutaneous tissue, muscle, tendon, and bone.

Indications

Wound care involves evaluation and treatment of a wound. Wound care thus involves identifying potential causes of delayed wound healing and modification of treatment as directed by the certifying physician. Determining the agent of delayed wound healing such as vascular disease, infection, diabetes or other metabolic disorders, immunosuppression, unrelieved pressure, radiation injury and

malnutrition will help determine the course of treatment. Evaluations could include comprehensive medical evaluation, vascular evaluation, orthopedic evaluation and metabolic/nutritional evaluation leading to a plan of care. The plan may include metabolic corrections including dietary supplementation, specialized wound care, pressure relief, use of compression to manage edema, debridement and reconstruction, rehabilitation therapy, possible general, vascular and/or orthopedic surgery, and antimicrobial agents.

In order to be covered under Medicare, a service must be reasonable and necessary. Among the requirements for a reasonable and necessary service are that the service be safe and effective, furnished in the appropriate setting, and ordered and/or furnished by qualified personnel.

Evaluation of wounds

Wound care involves the evaluation and treatment of a wound, including identifying potential causes of delayed wound healing and the modification of treatment when indicated. Evaluations may require a comprehensive medical evaluation, vascular evaluation, orthopedic evaluation, functional evaluation, metabolic/nutritional evaluation, and a plan of care.

Medicare coverage for wound care on a continuing basis for a given wound in a given patient is contingent upon evidence documented in the patient's record that the wound is improving in response to the wound care being provided. It is neither reasonable nor medically necessary to continue a given type of wound care if evidence of wound improvement cannot be shown as long as the overall goal of care for the specific patient is healing and not palliation. It is, however, anticipated that at least one of the following metrics would be addressed with palliative care, and the reason(s) for palliative care would be clearly documented and discussed with the patient (or patient's representative). Evidence of improvement includes measurable changes in at least some of the following:

Drainage

Inflammation

Swelling

Pain and/or tenderness

Wound dimensions (surface measurements, depth)

Granulation tissue

Necrotic tissue/slough

Tunneling or undermining

A wound that shows no improvement after 30 days requires a new approach, which may include a physician reassessment of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment approach.

In rare instances, the goal of wound care provided in outpatient settings may be only to prevent progression of the wound, which, due to severe underlying debility or other factors such as inoperability, is not expected to improve. In this case the focus of the care should be to transition the patient for self care or to the patient's care giver for continued care of the wound if feasible based on the patient and/or caregiver's cognitive ability to perform wound self care. In such cases, this would clearly be documented in the patient's clinical record.

However, when wound care is provided, utilizing therapy services, the CMS Documentation Requirements for Therapy Services must be followed as instructed in the CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 220.3 which states:

"220.3 - Documentation Requirements for Therapy Services

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare manuals. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all legal/regulatory requirements applicable to Medicare claims.

The documentation guidelines in sections 220 and 230 of this chapter identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies of the profession, the practice, or the facility may be more stringent. Additional documentation not required by Medicare is encouraged when it conforms to state or local law or to professional guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language Hearing Association. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed. (See also section 220.2- Reasonable and Necessary Outpatient Rehabilitation Therapy Services)

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

B. Documentation Required

List of required documentation. These types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise. The timelines are minimum requirements for Medicare payment. Document as often as the clinician's judgment dictates but no less than the frequency required in Medicare policy:

Evaluation /and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;

Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.

Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);

Treatment Notes for each treatment day (may also serve as Progress Reports when required information is included in the notes); and

A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

Limits on Requirements. Contractors shall not require more specific documentation unless other Medicare manual policies require it. Contractors may request further information to be included in these documents concerning specific cases under review when that information is relevant, but not submitted with records.

Dictated Documentation. For Medicare purposes, dictated therapy documentation is considered completed on the day it was dictated. The qualified professional may edit and electronically sign the documentation at a later date.

Dates for Documentation. The date the documentation was made is important only to establish the date of the initial plan of care because therapy cannot begin until the plan is established unless treatment is performed or supervised by the same clinician who establishes the plan. However, contractors may require that treatment notes and progress reports be entered into the record within 1 week of the last date to which the Progress Report or Treatment Note refers. For example, if treatment began on the first of the month at a frequency of twice a week, a Progress Report would be required at the end of the month. Contractors may require that the Progress Report that describes that month of treatment be dated not more than 1 week after the end of the month described in the report.

Document Information to Meet Requirements. In documenting records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services as described in the manuals. For example, the records should justify:

The patient is under the care of a physician/NPP;

Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and

Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, and correspondence.

Services require the skills of a therapist.

Services must not only be provided by the qualified professional or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of the patient during each Progress Report Period. In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.

A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.

Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.

Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.

Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.

Documentation should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.

Needs of the Patient. When a service is reasonable and necessary, the patient also needs the services. Contractors determine the patient's needs through knowledge of the individual patient's condition, and any complexities that impact that condition, as described in documentation (usually in the evaluation, re-evaluation, and Progress Report). Factors that contribute to need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability. Patients who need therapy generally respond to therapy, so changes in objective and sometimes to subjective measures of improvement also help establish the need for services. The use of scientific evidence, obtained from professional literature, and sequential measurements of the patient's condition during treatment is encouraged to support the potential for continued improvement that may justify the patient's need for therapy."

Dressings

Wet dressings: Water and medication can be applied to the skin with dressings (finely woven cotton, linen, or gauze) soaked in solution. Wet compresses, especially with frequent changes, provide gentle debridement.

Dry dressings: Used to protect the skin, hold medications against the skin, keep clothing and sheets from rubbing, or keep dirt and air away. Such dressings also prevent patients from scratching or rubbing.

Advanced dressings: Used with increasing frequency in the treatment of acute wounds, chronic venous, diabetic and pressure ulcers. A variety of dressings are available including transparent films, foams, hydrocolloids, and hydrogels.

Dressing changes (removal and subsequent reapplication) alone do not require the skills of physicians, podiatrists, physical therapists, occupational therapists or wound care nurses and in fact are usually performed by non-physician providers. When performed in conjunction with another wound care service, the dressing change is considered an integral component of that service.

Active Wound Care Management

Active wound care procedures are performed to remove devitalized tissue and promote healing, and involve selective and non-selective debridement techniques.

1. Wound Care Selective - CPT 97597, 97598

Debridement is usually indicated whenever necrotic tissue is present on an open wound. Debridement may also be indicated in cases of abnormal wound healing or repair. Debridement will not be considered a reasonable and necessary procedure for a wound that is clean and free of necrotic tissue or in the absence of abnormal wound healing. Selective debridement should only be provided under a certified plan of care.

Conservative sharp debridement: Conservative sharp debridement is the classical method of selective wound debridement. Conservative sharp debridement is a minor procedure that typically requires no anesthesia. Scalpel, curettes, scissors and tweezers/forceps may be used and only clearly identified devitalized tissue is removed. Generally, there is no bleeding associated with this procedure.

Whirlpool: Whirlpool provides a means where a wound can be submerged in water and, if appropriate, an additive agent is used for cleansing. Whirlpool may be covered 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 physical therapist may be required to perform an accurate assessment of the patient and the wound to assure the medical necessity of the whirlpool for the specific wound type. The skills, knowledge and judgment of a qualified physical 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.

Lavage (non-immersion hydrotherapy) involves the use of an irrigation device, with or without pulsation, 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 it is irrigated.

2. Wound Care Non-Selective - CPT 97602

Note – Currently, code 97602 is a status B (bundled) code on the MFSDB for Medicare Part B services; therefore, separate payment is not allowed for this service. Code 97602 is status T (significant procedure subject to multiple procedure discounting) on OPps for Medicare Part A services.

Blunt Debridement: 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 physician, podiatrist, therapist, or wound care nurse.

Enzymatic Debridement: Debridement with topical enzymes is 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 is the clinician's responsibility to comply with those guidelines.

Autolytic Debridement: This type of debridement is indicated where manageable amounts of necrotic tissue are present, and there is no infection. Autolytic debridement occurs when the enzymes that are naturally found in wound fluids are sequestered under synthetic dressings; it is contraindicated for infected wounds.

Mechanical Debridement: Wet-to-dry dressings may be used with wounds that have a high percentage of necrotic tissue. Wet-to-dry dressings should be used cautiously as maceration of surrounding tissue may hinder healing.

Jet Hydrotherapy and Wound Irrigation: Mechanical debridement is 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 a covered service.

3. Negative Pressure Wound Care – CPT 97605, 97606

Negative wound pressure therapy is a procedure that manages wound exudates and promotes wound closure. The vacuum cleanses the wound and stimulates the wound bed, reduces localized edema and improves local oxygen supply.

Active Wound Care Management – CPT 97597, 97598, 97602, 97605, and 97606

CPT 97597, 97598, 97602, 97605 and 97606 fall under the CPT code section Physical Medicine and Rehabilitation. These services may be performed by non-therapists when permitted by the scope of practice requirements of each state. When wound care is provided utilizing therapy services, the CMS guidelines regarding therapy plans of care as stated in the CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 220 apply. Specifically, Section 220.1.2 states:

"220.1.2 - Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

Reference: 42CFR 410.61

A. Establishing the plan (See §220.1.3 for certifying the plan.)

The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan, which is described in §§220.1.1 and 220.1.3

Outpatient therapy services shall be furnished under a plan established by:

A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF);

The physical therapist who will provide the physical therapy services;

The occupational therapist who will provide the occupational therapy services; or

The speech-language pathologist who will provide the speech-language pathology services.

The plan may be entered into the patient's therapy record either by the person who established the plan or by the provider's or supplier's staff when they make a written record of that person's oral orders before treatment is begun.

Treatment under a Plan. The evaluation and treatment may occur and are both billable either on the same day or at subsequent visits. It is appropriate that treatment begins when a plan is established.

Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same clinician who establishes the plan. Payment for services provided before a plan is established may be denied.

Two Plans. It is acceptable to treat under two separate plans of care when different physician's/NPP's refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The Treatment Notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress Reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate Progress Reports referencing each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

B. Contents of Plan (See §220.1.3 for certifying the plan.)

The plan of care shall contain, at minimum, the following information as required by regulation (42 CFR 424.24 and 410.61) (See §220.3 for further documentation requirements):

Diagnoses;

Long term treatment goals; and

Type, amount, duration and frequency of therapy services.

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. When episodes in the setting are short, measurable goals may not be achievable; documentation should state the clinical reasons progress cannot be shown.

The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. (For example, where there is a single evaluation service, but the type is not specified, the type is assumed to be consistent with the therapy discipline (PT, OT, SLP) ordered,

or of the therapist who provided the evaluation.) Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the required information is present and related to each discipline separately. For example, a physical therapist may not provide services under an occupational therapist plan of care. However, both may be treating the patient for the same condition at different times in the same day for goals consistent with their own scope of practice.

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.

The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing Progress Reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.

The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.

It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks. When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient

and/or caregiver to do more independent self management as treatment progresses, and any other factors related to frequency and duration of treatment.

The above policy describes the minimum requirements for payment. It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these optional elements: short term goals, goals and duration for the current episode of care, specific treatment interventions, procedures, modalities or techniques and the amount of each. Also, notations in the medical record of beginning date for the plan are recommended but not required to assist Medicare contractors in determining the dates of services for which the plan was effective.

C. Changes to the Therapy Plan

Changes are made in writing in the patient's record and signed by one of the following professionals responsible for the patient's care:

The physician/NPP;

The physical therapist (in the case of physical therapy);

The speech-language pathologist (in the case of speech-language pathology services);

The occupational therapist (in the case of occupational therapy services; or

The registered professional nurse or physician/NPP on the staff of the facility pursuant to the oral orders of the physician/NPP or therapist.

While the physician/NPP may change a plan of treatment established by the therapist providing such services, the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval [See §220.1.3(C)]. A change in long-term goals, (for example if a new condition was to be treated) would be a significant change.

Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan. An insignificant alteration in the plan would be a change in the frequency or duration due to the patient's illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals. If a patient has achieved a goal and/or has had no response to a treatment that is part of the plan, the therapist may delete a specific intervention from the plan of care prior to physician/ NPP approval. This shall be reported to the physician/NPP responsible for the patient's treatment prior to the next certification.

Procedures (e.g., neuromuscular reeducation) and modalities (e.g., ultrasound) are not goals, but are the means by which long and short term goals are obtained. Changes to procedures and modalities do not require physician signature when they represent adjustments to the plan that result from a normal progression in the patient's disease or condition or adjustments to the plan due to lack of expected response to the planned intervention, when the goals remain unchanged. Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's

signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities). "

A wound that shows no improvement after 30 days may require a new approach, which should include a physician reassessment of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment approach.

In rare instances, the goal of wound care provided in an outpatient setting may be only to prevent progression of the wound, which, due to severe underlying debility or other factors such as inoperability, is not expected to improve.

Standard wound care includes assessment of a patient's vascular status and correction of any vascular problems in the affected area, controlling infection, optimization of nutritional status (including glucose control), and debridement by appropriate means to remove devitalized tissue. Patients with wounds that are associated with ischemia that has not been evaluated and treated, abscess formation, active infection, exposed tendons or bones, wet or dry gangrene, and or otherwise cannot be treated with local care should have general, vascular and/or orthopedic surgery consultations in their documentation.

Surgical Debridements - CPT 11000-11001 and 11042-11047

The CPT for the 11000-11047 series of codes may be billed by physicians as defined by Medicare and when within the scope of practice according to State law, by other health care providers. Additionally, these codes represent extensive debridement procedures. The documentation for these procedures should include the indications for the procedure, the type of anesthesia if and when used, and the narrative of the procedure that describes the wounds and the details of the debridement procedure itself. The debridement code submitted should reflect the type of tissue removed during the procedure and not the depth, size, or other characteristics of the wound. For example, if a wound involves exposed bone but the debridement procedure did not remove bone, CPT code 11044 cannot be billed.

Use of E/M Codes in Conjunction with Surgical Debridements

Patients who have chronic wounds almost always have underlying medical problems that require concomitant management in order to bring about wound closure. In addition patients may require education, other services, and coordination of care both in the preoperative and postoperative phases of the debridement procedure. When providing and billing surgical debridements, the surgical debridement service is to include: the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the patient on the date of the service. When a "reasonable and necessary" Evaluation and Management (E&M) service is provided and documented on the same day as a debridement service, it is payable by Medicare when the documentation clearly establishes the service as a "separately identifiable service" that was reasonable and necessary, as well as distinct, from the debridement service(s) provided.

Application of Unna Boots (CPT 29580) and Surgical Debridements

Unna boot is a type of compression dressing used to promote return of blood from the peripheral veins back into the central circulation. When both a debridement is done and an Unna boot is applied only the debridement will be reimbursed. If only an Unna boot is applied and the wound is not debrided, then the Unna boot application is eligible for reimbursement.

Limitations

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.

Debridement of the wound(s), if indicated, must be done judiciously and at appropriate intervals. If there is no necrotic, devitalized, fibrotic, or other tissue or foreign matter present that would interfere with wound healing, debridement is not medically necessary. The presence or absence of such tissue or foreign matter must be documented in the medical record. If required, it is expected that the frequency of debridement will decrease over time.

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. Wound care that can be performed by the patient or the patient's caregiver will be considered to be maintenance care. Reassessment of a wound maintained by the patient or patient's caregiver is covered as a physician evaluation and management service.

Various methods to promote wound healing have been devised over time. Physicians and health care providers must understand that many of these methods are expensive and unproven by valid scientific literature, and would be considered investigational. Investigational treatments are noncovered by Medicare as not medically necessary. The patient can be requested to pay for investigational treatment under waiver of liability provisions of Medicare law, but an Advance Beneficiary Notice must be obtained for the beneficiary to be liable for such payment.

This policy excludes the management of acute wounds, the care of wounds that normally heal by primary intention, such as clean, incised traumatic wounds, surgical wounds which are closed primarily, and other postoperative wound care not separately payable during the surgical global period.

Procedures performed for cosmetic reasons or to prepare tissues for cosmetic procedures are statutorily excluded from coverage by Medicare.

Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia are included in the reimbursement for wound care services and are not separately payable.

The following procedures are considered part of an evaluation and management (E&M) service or wound care management services, and are not separately covered: 1) removal of necrotic tissue by cleansing and dressing, including wet-to-dry dressing changes; 2) cleaning and dressing small or superficial lesions; and 3) removal of coagulated serum from normal skin surrounding an ulcer.

Low Frequency, Non-Contact, Non-Thermal Ultrasound (MIST Therapy)

CPT/HCPCS code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care, per day) describes a system that uses continuous low frequency ultrasonic energy to produce and propel a mist of liquid and deliver continuous low frequency ultrasound to the wound bed. This modality is often referred to as "MIST Therapy".

Low frequency, non-contact, non-thermal ultrasound (MIST Therapy) will be considered "reasonable and necessary" wound therapy and therefore eligible for coverage by Medicare when provided as wound therapy for any of the following clinical conditions:

Acute or chronic painful venous stasis ulcers, which are too painful for sharp or excisional debridement;

Acute or chronic arterial/ischemic ulcers, which are too painful for sharp or excisional debridement;

Diabetic or neuropathic ulcers;

Radiation injuries or ulcers;

Patients with wounds or ulcers with documented contraindications to sharp or excisional debridement;

Burns which are painful and/or have significant necrotic tissue;

Wounds that have not demonstrated signs of improvement after 30 days of documented standard wound care; or

Preparation of wound bed sites for application of bioengineered skin products or skin grafting.

Frequency/Duration

Low frequency, non-contact, non-thermal ultrasound (MIST Therapy) must be provided 2-3 times per week to be considered "reasonable and necessary." The length of individual treatments will vary per wound size according to manufacturer recommendations.

Observable, documented improvements in the wound(s) should be evident after 2 weeks or 6 treatments. Improvements would include documented reduction in pain, necrotic tissue, or wound size or improved granulation tissue.

Medicare will cover up to 6 weeks or 18 treatments with documented improvements of pain reduction, reduction in wound size, improved and increased granulation tissue, or reduction in necrotic tissue. Continued treatments beyond 18 sessions per episode of treatment will be considered only upon individual consideration.

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[Coding Information](#)

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 011x Hospital Inpatient (Including Medicare Part A)
- 012x Hospital Inpatient (Medicare Part B only)
- 013x Hospital Outpatient
- 018x Hospital - Swing Beds
- 021x Skilled Nursing - Inpatient (Including Medicare Part A)
- 022x Skilled Nursing - Inpatient (Medicare Part B only)
- 023x Skilled Nursing - Outpatient
- 071x Clinic - Rural Health
- 074x Clinic - Outpatient Rehabilitation Facility (ORF)
- 075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
- 083x Ambulatory Surgery Center
- 085x Critical Access Hospital

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

- 027X Medical/Surgical Supplies and Devices - General Classification
- 036X Operating Room Services - General Classification
- 042X Physical Therapy - General Classification
- 043X Occupational Therapy - General Classification

- 045X Emergency Room - General Classification
- 049X Ambulatory Surgical Care - General Classification
- 0510 Clinic - General Classification
- 0520 Free-Standing Clinic - General Classification
- 0521 Free-Standing Clinic - Clinic Visit by Member to RHC/FQHC
- 0524 Free-Standing Clinic - Visit by RHC/FQHC Practitioner to a Member in a Covered Part A Stay at SNF
- 0525 Free-Standing Clinic - Visit by RHC/FQHC Practitioner to a Member in a SNF (not in a Covered Part A Stay) or NF or ICF MR or Other Residential Facility
- 0623 Medical Surgical Supplies - Surgical Dressings
- 0761 Specialty Services - Treatment Room

CPT/HCPCS Codes

Italicized and/or quoted material is excerpted from the American Medical Association, Current Procedural Terminology (CPT) codes.

- 11000 DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE
- 11001 DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; EACH ADDITIONAL 10% OF THE BODY SURFACE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY 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)

29580 STRAPPING; UNNA BOOT

97022 APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL

97597 DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS, BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; FIRST 20 SQ CM OR LESS

97598 DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL AND FORCEPS), OPEN WOUND, (EG, FIBRIN, DEVITALIZED EPIDERMIS AND/OR DERMIS, EXUDATE, DEBRIS, BIOFILM), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, USE OF A WHIRLPOOL, WHEN PERFORMED AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION, TOTAL WOUND(S) SURFACE AREA; EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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

G0456 NEGATIVE PRESSURE WOUND THERAPY, (E.G. VACUUM ASSISTED DRAINAGE COLLECTION) USING A MECHANICALLY-POWERED DEVICE, NOT DURABLE MEDICAL EQUIPMENT, INCLUDING PROVISION OF CARTRIDGE AND DRESSING(S), TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE, PER SESSION; TOTAL WOUNDS(S) SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS

G0457 NEGATIVE PRESSURE WOUND THERAPY, (E.G. VACUUM ASSISTED DRAINAGE COLLECTION) USING A MECHANICALLY-POWERED DEVICE, NOT DURABLE MEDICAL EQUIPMENT, INCLUDING PROVISION OF CARTRIDGE AND DRESSING(S), TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIONS FOR ONGOING CARE, PER SESSION; TOTAL WOUNDS(S) SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS

0183T LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND, INCLUDING TOPICAL APPLICATION(S), WHEN PERFORMED, WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER DAY

ICD-9 Codes that Support Medical Necessity

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

017.00 - 017.06 TUBERCULOSIS OF SKIN AND SUBCUTANEOUS CELLULAR TISSUE UNSPECIFIED EXAMINATION - TUBERCULOSIS OF SKIN AND SUBCUTANEOUS CELLULAR TISSUE TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

021.0 ULCEROGLANDULAR TULAREMIA

022.0 CUTANEOUS ANTHRAX

024 GLANDERS

031.1 CUTANEOUS DISEASES DUE TO OTHER MYCOBACTERIA

039.0 - 039.9 CUTANEOUS ACTINOMYCOTIC INFECTION - ACTINOMYCOTIC INFECTION OF UNSPECIFIED SITE

040.0 GAS GANGRENE

085.1 - 085.5 CUTANEOUS LEISHMANIASIS URBAN - MUCOCUTANEOUS LEISHMANIASIS (AMERICAN)

110.0 DERMATOPHYTOSIS OF SCALP AND BEARD

110.2 - 110.9 DERMATOPHYTOSIS OF HAND - DERMATOPHYTOSIS OF UNSPECIFIED SITE

116.0 - 116.2 BLASTOMYCOSIS - LOBOMYCOSIS

172.0 - 172.8 MALIGNANT MELANOMA OF SKIN OF LIP - MALIGNANT MELANOMA OF OTHER SPECIFIED SITES OF SKIN

173.00 - 173.99 UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LIP - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN, SITE UNSPECIFIED

174.0 - 174.9 MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF FEMALE BREAST - MALIGNANT NEOPLASM OF BREAST (FEMALE) UNSPECIFIED SITE

175.0 MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF MALE BREAST

176.0 KAPOSI'S SARCOMA SKIN

198.2 SECONDARY MALIGNANT NEOPLASM OF SKIN

216.0 - 216.8 BENIGN NEOPLASM OF SKIN OF LIP - BENIGN NEOPLASM OF OTHER SPECIFIED SITES OF SKIN

232.0 - 232.8 CARCINOMA IN SITU OF SKIN OF LIP - CARCINOMA IN SITU OF OTHER SPECIFIED SITES OF SKIN

233.0 CARCINOMA IN SITU OF BREAST

249.70 - 249.71 SECONDARY DIABETES MELLITUS WITH PERIPHERAL CIRCULATORY DISORDERS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED - SECONDARY DIABETES MELLITUS WITH PERIPHERAL CIRCULATORY DISORDERS, UNCONTROLLED

250.80 - 250.83 DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

440.23 ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION

440.24 ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE

443.1 THROMBOANGIITIS OBLITERANS (BUERGER'S DISEASE)

454.0 VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER

454.2 VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION

459.11 POSTPHLEBETIC SYNDROME WITH ULCER

459.13 POSTPHLEBETIC SYNDROME WITH ULCER AND INFLAMMATION

459.31 CHRONIC VENOUS HYPERTENSION WITH ULCER

459.33 CHRONIC VENOUS HYPERTENSION WITH ULCER AND INFLAMMATION

565.0 - 565.1 ANAL FISSURE - ANAL FISTULA

566 ABSCESS OF ANAL AND RECTAL REGIONS

608.4 OTHER INFLAMMATORY DISORDERS OF MALE GENITAL ORGANS

608.83 VASCULAR DISORDERS OF MALE GENITAL ORGANS

611.0 INFLAMMATORY DISEASE OF BREAST

616.4 OTHER ABSCESS OF VULVA

616.50 - 616.51 ULCERATION OF VULVA UNSPECIFIED - ULCERATION OF VULVA IN DISEASES CLASSIFIED ELSEWHERE

619.2 GENITAL TRACT-SKIN FISTULA FEMALE

619.8 OTHER SPECIFIED FISTULAS INVOLVING FEMALE GENITAL TRACT

664.00 - 664.44 FIRST-DEGREE PERINEAL LACERATION UNSPECIFIED AS TO EPISODE OF CARE IN PREGNANCY - UNSPECIFIED PERINEAL LACERATION POSTPARTUM

674.10 - 674.14 DISRUPTION OF CESAREAN WOUND UNSPECIFIED AS TO EPISODE OF CARE - DISRUPTION OF CESAREAN WOUND POSTPARTUM

674.20 - 674.24 DISRUPTION OF PERINEAL WOUND UNSPECIFIED AS TO EPISODE OF CARE IN PREGNANCY - DISRUPTION OF OBSTETRICAL PERINEAL WOUND POSTPARTUM

674.30 - 674.34 OTHER COMPLICATIONS OF OBSTETRICAL SURGICAL WOUNDS UNSPECIFIED AS TO EPISODE OF CARE - OTHER COMPLICATIONS OF OBSTETRICAL SURGICAL WOUNDS POSTPARTUM
CONDITION OR COMPLICATION

681.00 UNSPECIFIED CELLULITIS AND ABSCESS OF FINGER

681.10 UNSPECIFIED CELLULITIS AND ABSCESS OF TOE

682.0 - 682.9 CELLULITIS AND ABSCESS OF FACE - CELLULITIS AND ABSCESS OF UNSPECIFIED SITES

686.09 OTHER PYODERMA

686.9 UNSPECIFIED LOCAL INFECTION OF SKIN AND SUBCUTANEOUS TISSUE

705.83 HIDRADENITIS

707.00 - 707.9 PRESSURE ULCER, UNSPECIFIED SITE - CHRONIC ULCER OF UNSPECIFIED SITE

709.8 OTHER SPECIFIED DISORDERS OF SKIN

728.86 NECROTIZING FASCIITIS

729.91 - 729.92 POST-TRAUMATIC SEROMA - NONTRAUMATIC HEMATOMA OF SOFT TISSUE

730.00 - 730.20 ACUTE OSTEOMYELITIS SITE UNSPECIFIED - UNSPECIFIED OSTEOMYELITIS SITE
UNSPECIFIED

785.4 GANGRENE

870.0 - 870.2 LACERATION OF SKIN OF EYELID AND PERIOcular AREA - LACERATION OF EYELID
INVOLVING LACRIMAL PASSAGES

872.01 OPEN WOUND OF AURICLE UNCOMPLICATED

872.11 OPEN WOUND OF AURICLE COMPLICATED

873.0 OPEN WOUND OF SCALP WITHOUT COMPLICATION

873.1 OPEN WOUND OF SCALP COMPLICATED

873.20 - 873.22 OPEN WOUND OF NOSE UNSPECIFIED SITE UNCOMPLICATED - OPEN WOUND OF NASAL
CAVITY UNCOMPLICATED

873.32 - 873.33 OPEN WOUND OF NASAL CAVITY COMPLICATED - OPEN WOUND OF NASAL SINUS
COMPLICATED

873.41 - 873.49

OPEN WOUND OF CHEEK UNCOMPLICATED - OPEN WOUND OF OTHER AND MULTIPLE SITES
UNCOMPLICATED

873.51 - 873.59 OPEN WOUND OF CHEEK COMPLICATED - OPEN WOUND OF OTHER AND MULTIPLE
SITES COMPLICATED

874.8 - 874.9 OPEN WOUND OF OTHER AND UNSPECIFIED PARTS OF NECK WITHOUT COMPLICATION
- OPEN WOUND OF OTHER AND UNSPECIFIED PARTS OF NECK COMPLICATED

875.0 - 875.1 OPEN WOUND OF CHEST (WALL) WITHOUT COMPLICATION - OPEN WOUND OF CHEST
(WALL) COMPLICATED

876.0 - 876.1 OPEN WOUND OF BACK WITHOUT COMPLICATION - OPEN WOUND OF BACK
COMPLICATED

877.0 - 877.1 OPEN WOUND OF BUTTOCK WITHOUT COMPLICATION - OPEN WOUND OF BUTTOCK
COMPLICATED

878.0 - 878.9 OPEN WOUND OF PENIS WITHOUT COMPLICATION - OPEN WOUND OF OTHER AND
UNSPECIFIED PARTS OF GENITAL ORGANS COMPLICATED

879.0 - 879.9 OPEN WOUND OF BREAST WITHOUT COMPLICATION - OPEN WOUND(S) (MULTIPLE) OF
UNSPECIFIED SITE(S) COMPLICATED

880.00 - 880.29 OPEN WOUND OF SHOULDER REGION WITHOUT COMPLICATION - OPEN WOUND OF MULTIPLE SITES OF SHOULDER AND UPPER ARM WITH TENDON INVOLVEMENT

881.00 - 881.22 OPEN WOUND OF FOREARM WITHOUT COMPLICATION - OPEN WOUND OF WRIST WITH TENDON INVOLVEMENT

882.0 - 882.2 OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITHOUT COMPLICATION - OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITH TENDON INVOLVEMENT

883.0 - 883.2 OPEN WOUND OF FINGERS WITHOUT COMPLICATION - OPEN WOUND OF FINGERS WITH TENDON INVOLVEMENT

884.0 - 884.2 MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITHOUT COMPLICATION - MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT

885.0 - 885.1 TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) COMPLICATED

886.0 - 886.1 TRAUMATIC AMPUTATION OF OTHER FINGER(S) (COMPLETE) (PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF OTHER FINGER(S) (COMPLETE) (PARTIAL) COMPLICATED

887.0 - 887.7 TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) UNILATERAL BELOW ELBOW WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED

890.0 - 890.2 OPEN WOUND OF HIP AND THIGH WITHOUT COMPLICATION - OPEN WOUND OF HIP AND THIGH WITH TENDON INVOLVEMENT

891.0 - 891.2 OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITHOUT COMPLICATION - OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITH TENDON INVOLVEMENT

892.0 - 892.2 OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITHOUT COMPLICATION - OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITH TENDON INVOLVEMENT

893.0 - 893.2 OPEN WOUND OF TOE(S) WITHOUT COMPLICATION - OPEN WOUND OF TOE(S) WITH TENDON INVOLVEMENT

894.0 - 894.2 MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB WITHOUT COMPLICATION - MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB WITH TENDON INVOLVEMENT

895.0 - 895.1 TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) COMPLICATED

896.0 - 896.3 TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) UNILATERAL WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) BILATERAL COMPLICATED

897.0 - 897.7 TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL BELOW KNEE WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED

997.60 UNSPECIFIED LATE COMPLICATION OF AMPUTATION STUMP

997.62 INFECTION (CHRONIC) OF AMPUTATION STUMP

997.69 OTHER LATE AMPUTATION STUMP COMPLICATION

998.30 - 998.33 DISRUPTION OF WOUND, UNSPECIFIED - DISRUPTION OF TRAUMATIC INJURY WOUND REPAIR

998.51 - 998.59 INFECTED POSTOPERATIVE SEROMA - OTHER POSTOPERATIVE INFECTION

998.6 PERSISTENT POSTOPERATIVE FISTULA NOT ELSEWHERE CLASSIFIED

998.83 NON-HEALING SURGICAL WOUND

Diagnoses that Support Medical Necessity

Conditions that are listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity

All those not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Conditions that are not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

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Other Information

Documentation Requirements

All documentation must be maintained in the patient's medical record and available to the contractor upon request.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.

The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

The most accurate and specific diagnosis code(s) must be submitted on the claim. The patient's medical record should indicate the specific signs/symptoms, and other clinical data supporting the diagnosis code(s) used. It is expected that the physician will document the status of the wound in the patient's medical record and the patient's response to the treatment.

When reporting codes 11000-11001 and 11042-11047 it is expected that the documentation will include the following:

Medical diagnosis

Indication(s) for the debridement

Type of anesthesia used, if and when used

Level/depth of tissue debrided

Wound characteristics such as diameter, color, presence of exudates or necrotic tissue

Vascular status

Narrative of the procedure

Patient specific goals and/or response to treatment

When reporting code(s) 11000 and 11001, the percentage of body surface area being debrided must be clearly documented in the medical record.

When reporting codes 11042-11047, the documentation in the medical record must clearly reflect the depth/thickness of the tissue being removed and not the depth of the wound itself.

Wound progress must be documented noting an improvement in the wound characteristics (i.e., surface dimensions, depth, amount of necrotic tissue, amount of exudate, etc.).

Additional Information

Please see article A47793, Wound Care, for additional information.

Reference LCD L31686, Services That Are Not Reasonable and Necessary, for information regarding Category III codes.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Sources of Information and Basis for Decision

Contractor is not responsible for the continued viability of websites listed.

Agency for Healthcare Research and Quality. Usual care in the Management of Chronic Wounds: A review of the Recent Literature. 03/08/2005 Technology Assessment.

Agency for Healthcare Research and Quality. Wound-Healing Technologies: Low-Level Laser and Vacuum-Assisted Closures. Evidence Report/Technology Assessment: Number 111.

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Bell AL, Cavorsi J. Noncontact Ultrasound Therapy for Adjunctive Treatment of Nonhealing Wounds: Retrospective Analysis. *Physical Therapy* 2008; 88(12):1517-1524.

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Haan J, Lucich S. A Retrospective Analysis of Acoustic Pressure Wound Therapy: Effects on the Healing Progression of Chronic Wounds. Journal of the American College of Certified Wound Specialists 2009; 1:28-34.

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Kavros SJ, Miller JL, Hanna SW. Treatment of Ischemic Wounds with Noncontact, Low-Frequency Ultrasound: The Mayo Clinic Experience, 2004-2006. Advances in Skin and Wound Care 2007; 20(4):221-6.

Kavros SJ, Liedl DA, Boon AJ et al. Expedited Wound Healing with Noncontact, Low-Frequency Ultrasound Therapy in Chronic Wounds: A Retrospective Analysis. Advances in Skin and Wound Care 2008; 21 (9):416-23.

Kavros SJ, Schenck EC. Use of Noncontact Low-Frequency Ultrasound in the Treatment of Chronic Foot and Leg Ulcerations, A 51-Patient Analysis. Journal of the American Podiatric Medical Association 2007; 97(2): 95-101.

MIST Therapy System marketing information

Serena T, Lee SK, Lam K et al. The Impact of Noncontact, Nonthermal, Low Frequency Ultrasound on Bacterial Counts in Experimental and Chronic Wounds. Ostomy Wound Management 2009; 55(1):22-30.

Sheffield PJ, et al. Wound Care Practice. Flagstaff, AZ: Best Publishing Co., 2004.

Other Contractors' Policies

Novitas Solutions Contractor Medical Directors

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Directors. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the appropriate specialty (ies).

CAC/IAC Distribution: 04/01/2008

CAC Distribution: 05/21/2009

Start Date of Comment Period

05/21/2009

End Date of Comment Period:

07/08/2009

Start Date of Notice Period

09/11/2009

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Revision History

Revision History Number

L27547

Revision History Explanation

Date	Policy #	Description
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01/01/2013		
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L27547

LCD revised for dates of service on and after 01/01/2013 to reflect the annual CPT/HCPCS code updates. The following code(s) have been added: G0456 and G0457.

06/13/2012

L27547

LCD revised based on a reconsideration request to allow coverage of procedure code 0183T effective for dates of service on and after 05/07/2012.

04/12/2012

L27547

LCD revised to remove coverage of Category III code 0183T in keeping with LCD L31686, Services That Are Not Reasonable and Necessary, effective for dates of service on and after 04/12/2012.

04/02/2012

L27547

LCD revised to reflect contractor name change from Highmark Medicare Services to Novitas Solutions, Inc.

12/14/2011

L27547

LCD revised to clarify that 97602 is status B for Medicare Part B services and status T for Medicare Part A services.

10/01/2011

L27547

LCD revised effective 10/01/2011 to reflect the ICD-9-CM update. The following codes have been deleted: 173.0-173.8. The following codes have been added; 173.00-173.99.

02/21/2011

L27547

Per Change Request 7135, this LCD is effective for dates of service on and after 02/21/2011 for those providers in the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia serviced by Wisconsin Physicians Service (WPS), contractor number 52280, that are being transitioned to Highmark Medicare Services, contractor number 12901, effective 02/21/2011.

01/05/2011

L27547

LCD revised to reflect the annual CPT/HCPCS update. Procedure codes 11040 and 11041 deleted, procedure codes 11042, 11043, 11044, 97597 and 97598 descriptor changes, and procedure codes 11045, 11046 and 11047 added as new codes effective 01/01/2011.

09/08/2010

L27547

LCD revised effective 09/09/2010. The descriptions have changed for the following bill type codes: 11, 12, 13, 18, 21, 22, 23, 71, 74, 75, 83, and 85 with an effective date of 07/01/2010. The descriptions have changed for the following revenue codes: 0270, 0271, 0272, 0273, 0274, 0275, 0276, 0277, 0278, 0279, 0360, 0361, 0362, 0367, 0369, 0420, 0421, 0422, 0423, 0424, 0429, 0430, 0431, .0432, 0433, 0434, 0439, 0450, 0451, 0452, 0456, 0459, 0490, 0499, 0510, 0520, 0521, 0524, 0525, 0623, and 0761 with an effective date of 07/01/2010. Some or all of these changes may be in code ranges. Changed reference to CMS' internet domain name from cms.hhs.gov to cms.gov due to 04/02/2010 change in domain name.

01/13/2010

L27547

LCD revised effective 01/14/2010. Chapter and subsection added to CMS National Coverage Policy section for CMS Medicare Benefit Policy Manual, Pub 100-02.

09/11/2009

L27547

Revised LCD posted for notice. Limited coverage for MIST Therapy provided (CPT/HCPCS code 0183T) based on comments/literature received. LCD to become effective 10/28/2009. Revenue codes 0521 and 0761 descriptors updated.

05/21/2009

DL27547

Draft LCD posted for comment. LCD updated to delineate non-coverage of CPT/HCPCS code 0183T, low frequency, non-contact, non-thermal ultrasound (MIST Therapy) as clinical efficacy unproven.

12/12/2008

L27547

LCD effective 12/12/2008 for Pennsylvania Part B. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Part B; Maryland Part A and Part B; New Jersey Part A and Part B; Pennsylvania Part A and Part B. The following CPT/HCPCS code changes will be effective 01/01/2009: Code description changes 11001 and 97022. Non-discretionary update to specifically clarify that when wound care is provided utilizing therapy services, the CMS instructions on Documentation Requirements for Therapy Services per the CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 220.3 and the

CMS instructions on Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Services, per the CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 220, apply. Clarified the use of E&M codes in conjunction with surgical debridements.

11/14/2008

L27547

LCD effective 11/14/2008 for New Jersey Part B and Delaware Part A. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Delaware Part B; Maryland Part A and Maryland Part B; New Jersey Part A and New Jersey Part B; Pennsylvania Part A.

09/24/2008

L27547

The following ICD-9 code changes will be effective 10/01/2008 due to ICD-9-CM annual updates. Revised code descriptors for codes 707.00-707.09, 998.31, and 998.32. Added new codes 249.70-249.71, 707.20-707.25, 998.30 and 998.33. Some of these changes are within a code range. LCD revision effective 09/25/2008.

08/29/2008

L27547

LCD effective 09/01/2008 for New Jersey Part A. Effective 09/01/2008, New Jersey Part A will be added to the other jurisdictions already effective: DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

08/01/2008

L27547

LCD effective 08/01/2008 for DC Part A, Maryland Part A, and Pennsylvania Part A. LCD is now effective for DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

05/23/2008

L27547

Original LCD posted for notice. LCD to become effective 07/11/2008 for Maryland Part B, DCMA Part B and Delaware Part B.

04/01/2008

Draft J12-D55

Original LCD posted for comment.

Reason for Change

HCPCS Addition/Deletion

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.