WOUND CARE SERVICES NEW POLICY LCD L38902& LCA A58565 11/2021

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Neither I nor my family have any financial relationship(s) to disclose

Disclosure will be made when a product is discussed for an unapproved use.

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LEARNING OBJECTIVES

- To notify our audience of the Noridian Medicare hold of skin substitutes
- To notify regarding the new NCD on PRP uses in wound care
- To understand to new LCD & LCA regarding wound care
- To understand the importance of uses the phrases and words from the LCD/LCA in the provider's documentation
- To understand that the LCD/LCA language will be used by the auditors when charts are reviewed
- To understand that Noridian is giving the providers time to adjust to the new LCD/LCA
- To understand that the LCA is just as important to follow as is the LCD
- To understand that when the LCD/LCA states "may", it is understood to be a requirement
- To allow our providers to modify their documentation and add the "Plan of Care" to their charting to stay compliant to the LCD/LCA

PRP FOR WOUND CARE

- New treatment modality for wound care
- Verbal communication from the Medical Director
- Placed as an NCD
- I can not find the NCD yet
- We will get more information in late Febuary

SKIN SUBSTITUTES

SKIN SUBSTITUTES

- Skin substitutes **are** being paid for **wound care indications**
- The use of skin substitutes is not covered in any LCD / LCA.
- There is no LCD / LCA regarding skin substitutes
- Providers are referred to the Manufacturer's Provider Instructions, and will be held to those terms of use, identified by the Q Code
- The skin substitutes, under medicare are authorized for DFU and (in some cases) venous ulcers
- Noridian Medicare is holding payment for Q Codes for all other uses of the skin substitutes and all liquid Q Codes
- **The skin substitutes : Amniotic and/or placental derived MEMBRANE codes used in non-wound indications as well as all LIQUID Q Code claims used in any situation. The claims will be held until further direction is received.**

MY CONCERN

- Since a large group of Q codes will be held, until further instructions are received,
- There is a chance that legitimate bills received by Noridian for Q codes associated with legitimate wound indications
- Will be held by mistake, by Noridian

- How to appeal when the Q code was not denied.

WHAT IF THE Q CODE OF MEMBRANE FOR A WOUND IS DENIED OR HELD?

- Appeal immediately
- Contact me
- Include the billing with the procedure coding and diagnosis coding, and denial code
- I will contact the Medical Director immediately, as he requested

SKIN SUBSTITUTES : DOCUMENTATION GUIDE

- There is presently no LCD / LCA to use for guidance in case of audit
- We, in LACPMA, are creating a monograph to help guide those who are using skin substitutes for wound healing in the documentation.
- Medical necessity
- Phrases
- Pre-application, application and post-application
- Coding

ADDITIONAL RESOURCES

- APMA website for webinars for wound care & coding

RESOURCES

- Documentation guide for skin substitutes. April 2022
- Sample POC
- Sample wound visit checklist

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WOUND CARE GUIDELINES

LOCAL CARRIER DETERMINATION – WOUND CARE

DL38902

LCD L38902

- Active
- Notice Period Ended 11/27/2021
- Does Not address:
  - HBO
  - Initial PT nor OT evaluations
  - Skin Substitutes
  - Platelet Rich Plasma injections (New NCD)
  - Electric Stim & Electromagnetic Tx of Specified Wounds (NCD 270.1)
  - Treatment of burns
  - DME

SUMMARY OF EVIDENCE

- Chronic wound
  - Defined as a wound that has failed to progress through normal healing in a timely manner (30 days failure of Standard of Care)
  - Generally occur in patients with co-morbidities such as diabetes or vascular disease
  - Older adults are more likely to have chronic ulcers and to have the quality of their lives affected by these ulcers
- Chronic ulcers include but are not limited to:
  - Diabetic ulcers
  - Venous ulcers
  - Pressure ulcers

EVIDENCE-BASED CLINICAL GUIDELINES SUPPORT

- Removal of necrotic tissue with debridement
- Maintaining moisture balance
- Selecting appropriate wound dressings to control excessive moisture or add additional moisture, depending on wound type
- Infection prevention and treatment when needed
- Evaluation and improvement of circulation to the wound area
- Frequent monitoring, evaluation and measurement of wounds to determine wound progress
- Offload Diabetic foot ulcers
- Appropriate positioning and support surfaces for pressure ulcers
- Compression for venous leg ulcers

ANALYSIS OF EVIDENCE: FREQUENCY OF DEBRIDEMENT

- The appropriate interval & frequency of debridement depends on the individual clinical characteristics of the patient and the extent of the wound.
- The extent and number of services should be medically necessary and reasonable based on the documented medical evaluation of the patient's condition, diagnosis and plan
- Given the varied nature and diversity of options available to the clinician, this **LCD does not strictly impose defined frequency limitations as such on wound care debridements, palliative wound treatments and other wound care services**
- **Opinion: It is generally understood that the frequency should not be more frequent than every few days (twice a week). Document the reason for frequency.**
  - **New necrosis, continued infection, undermining, worsening wound**
- **Note: the frequency of debridement is covered in several sections, limiting surgical debridement to 4. however that can be increased with proper documentation and medical necessity, as to why the debridement is necessary**

LCD COVERAGE DEFINITION (CHRONIC WOUNDS)

- Wounds/ulcers refractory to healing or complicated healing cycles due to:
  - Nature of the wound
  - Complicating metabolic / physiological factors
- Excludes:
  - Acute wounds passing through healing cycle
  - Wounds healing by primary intention
  - Surgical wounds with primary closure
  - Post-op wound care not separately covered during the global period
  - Methods unproven by scientific literature / not reasonable & necessary

WOUND CARE

- Evaluation and treatment of a wound
- Identification of potential causes delayed healing & modification of the treatment
- Wound evaluation leads to Plan of Care (POC) (Monthly)
  - Comprehensive medical evaluation
  - Vascular assessment
  - Metabolic
  - Nutritional evaluation
  - Plan to reduce pressure
  - Plan to control infection

POC SUGGESTIONS THAT NEED TO BE NOTED

- Functional evaluations by different specialties may be of value
- Integration of PT may be of value
- Mention these in documentation. Whether needed or not necessary

DEVELOPMENT OF ULCERS

- Ischemia
- Infection
- Abscess
- Trauma
- Prolonged pressure
- Repetitive stress
- Venous / Arterial insufficiency
- Edema
- Loss of sensation

MANAGEMENT OF ULCERS INCLUDE:

- Overall medical and surgical treatment of the cause
- Meticulous care of the ulcerated skin & other associated soft tissue with applications of medicines and dressings
- When reasonable and necessary, debridement of the **necrotic and devitalized tissue**
- Offloading of the external pressure source(s)

SYMPTOMATIC HYPERKERATOSIS

- Policy addresses the paring and cutting
- Coverable and not inclusive of the Routine Foot Care policy
- Medical records need to detail symptoms leading to the service

WOUND CARE ON A CONTINUING BASIS

- Evidence in med record that the wound healing being maintained in response to the wound care being provided.

- Consistent measurements:
  - Length x width x depth. Volume?
  - Measure longest segment as “length”
  - Measure longest segment at 90º from length as width
  - Personal: Never measure depth as ‘0’

DOCUMENTATION OF WOUND HEALING

- Undermining
  - Clock technique with the head at 12 o’clock. Depth via swab
- Tunneling
  - Clock technique with the head at 12 o’clock. Depth via swab
- Severe contractures
- Infection reported by describing exudate:
  - Amount
  - Turbidity
  - Color
  - Odor
  - And signs of infection (cellulitis) in the tissue surrounding the wound
- Necrosis: ultimate loss of tissue vitality. Presence impedes healing

ONGOING WOUND CARE

- May include debridement to promote healing
- Pt’s clinical status and wound characteristics determine:
  - Appropriate method of debridement
  - Frequency of treatment
  - Interval between treatments
- See “Covered Indications” for more info on debridement methods

GOALS OF ACUTE WOUND & CHRONIC ULCER CARE
PRIMARY GOALS – ACUTE WOUND

Primary Goals:

- Eventual wound closure
  - With or without grafts, cellular or tissue products, or other surgery
  - Surgery: amputation, wound excision, etc.

- In the case of severe underlying debility or other factors of operability, in the outpatient setting, the goals may only be to:
  - prevent progression of the wound and,
  - prevention of prolonged hospitalization

GOALS OF ACUTE WOUND & CHRONIC ULCER CARE SECONDARY GOAL

Secondary Goal:

- With appropriate management, wound may reach a state at which its care may be performed primarily by the patient/caregiver with **periodic** physician assessment and supervision

GOALS OF ACUTE WOUND & CHRONIC ULCER CARE PRIMARY GOAL – CHRONIC WOUNDS

Primary Goal:

- Eventual wound closure

STANDARD WOUND CARE MEASURES INCLUDE BUT NOT LIMITED TO:

- Appropriate control of:
  - Pressure (offloading, padding, appropriate footwear)
  - Infection
  - Vascular insufficiency (venous and arterial)
  - Metabolic derangement
  - Nutritional deficiency

WOUND DEBRIDEMENT

- Active Wound Care procedures
  - Non-Selective debridement
  - Selective debridement

- Surgical debridement

WOUND CARE

- Active wound care management
  - Selective (97597)
  - Non-Selective (97602)
- Surgical debridement
  - Most surgical specialists fall into this category
  - 11042 series

- Different coding in each category
- Different documentation is each category

ACTIVE WOUND CARE MANAGEMENT

- The 97597 series
  - 97597 (selective debridement)
  - 97598
  - 97602 (non-selective) (w/o anesthesia)
  - 97605 (Neg Pressure Wound Therapy DME </= 50 sq cm)
  - 97606 (Neg Pressure Wound Therapy DME > 50 sq cm)
  - 97607 (Neg Pressure Wound Therapy non-DME </= 50 sq cm)
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- The 11402 series is not used in Active Wound Care Management
  - Excision benign lesion

ACTIVE WOUND CARE MANAGEMENT 97597, 97598, 97602

- **Active Wound Care Management is separate from Surgical Debridement**
- Code 97602 is a Status B (Bundled) code for physician services; therefor separate payment is not allowed for this service
- Code 97602 (non-selective debridement of non-viable tissue from wound without anesthesia, ie: wet-to-dry
- Debridement should be coded with either selective or non-selective CPT codes unless medical record supports a surgical debridement has been performed.
- Dressings applied to the wound on the day of the service are part of the service and can not be billed separately
- CPT 97602 can not be billed same day as 97597/97598

97597 VS. 11043

- Codes 97597/97598/97602 can not be reported in conjunction with the 11043-11047 code series for the same wound
- Wound depth determines the code
- If only biofilm is debrided on the surface of a muscular ulceration, then use codes 97597/97598
- If the muscle substance is debrided, use codes 11043-11046

CODES 97602 / 97605 / 97606 / 97608

- Includes application of, and removal of, any protective devices or bulk dressings
- If dressing change is performed without any active wound procedure, then do not code with these CPT codes
  - E/M would be appropriate

ACTIVE WOUND CARE PROCEDURES

- Debridement techniques
- Performed to remove devitalized tissue and promote healing
- Provider with "one-on-one" patient contact
- Interval and frequency of debridement
  - Extent of the wound
  - Clinical characteristics of the patient
- Frequent debridement
  - Reassess and re-examine treatment plan
  - Address all facets of care

RE-EVALUATION: ISSUES TO ADDRESS FOR FREQUENT REPEATED DEBRIDEMENT

- Regular Frequency – Monthly POC

- Determine whether the treatment goals are being met
  - Pressure reduction
  - Nutritional status
  - Vascular insufficiency (arterial and venous)
  - Infection control
  - Metabolic disease (diabetes, etc)

DEFINITION OF TERMS

- Dressing changes:
  - Wet dressings: water and meds applied to skin with dressings (cotton or gauze). Wet compresses w frequent changes provide gentle debridement.
  - Dry dressings: gentle debridement, protect skin, hold medicines against skin, keep clothing and sheets from rubbing, keep dirt and air away, avoid scratching and rubbing the wound
  - Advanced dressings: acute wounds, chronic venous wounds, diabetic and pressure ulcers. Used for gentle debridement, moisture control, prevent bacterial overgrowth, thermal insulation and physical protection.

- Dressing changes alone are not procedures by themselves; are included in the debridement or in the E/M visit.

COVERED INDICATIONS

TYPES OF WOUNDS NEEDING WOUND CARE

- Surgical wounds left open to heal via secondary intention
- Trauma wounds, open and infected
- Surgical wounds, open and infected
- Wounds with biofilm
- Wounds associated with complicating autoimmune, metabolic, vascular and/or pressure factors
- Wounds complicated by necrotic tissue and/or eschar

ACTIVE WOUND CARE MANAGEMENT

- Debridement indicated:
  - To keep wound in active state of healing
  - To remove necrotic tissue, cellular debris, proteinaceous debris
  - To address abnormal wound healing or repair

- Routine application of local or topical anesthetic will not elevate wound care management to surgical debridement.
- Debridement under Active Wound Care is either selective or non-selective

ACTIVE WOUND CARE MANAGEMENT SELECTIVE DEBRIDEMENT:

- Removal of specific, targeted areas of devitalized or necrotic tissue from a wound along the margin of viable tissue by sharp dissection.
- Utilizing: scissors, scalpel, curette, and/or tweezers/forceps
- Typically requires no anesthesia
- Generally minimal or no bleeding

ACTIVE WOUND CARE MANAGEMENT NON-SELECTIVE DEBRIDEMENT

- Mechanical
  - Removal of necrotic tissue by cleansing or appropriate dressings
  - Removal of debris and dressing changes are not considered a skilled or separate service
- Enzymatic
  - Debridement with topical enzymes used for protein, fiber and collagen.
  - Clinician to comply with packet insert, manufacturer's guidelines
- Autolytic
  - Indicated when manageable amount to necrotic tissue present and no infection.
  - Occurs when enzymes naturally found in wound fluids are sequestered under synthetic, non-permeable dressings
- Maggot / larvae
  - Debridement with medical grade maggots in wounds

WOUND CARE SURGICAL DEBRIDEMENTS

- Conditions that may require surgical debridement of large amounts of skin may include, but are not limited to:
  - Rapidly spreading necrotizing process
  - Severe eczema
  - Extensive skin trauma (including large abraded areas with ground-in dirt)!!
  - Autoimmune skin disease

WOUND CARE SURGICAL DEBRIDEMENTS

- Surgical debridement occurs when
  - Material has been excised
  - Reported for the treatment of a wound to clear and maintain the site free of devitalized tissue, including:
    - Necrosis
    - Eschar
    - Slough
    - Infected tissue
    - Biofilm
    - Abnormal granulation tissue
  - Should be accomplished to the margins of the viable tissue
  - These procedures can be very effective, but represent extensive debridement. May be complex and may require use of anesthesia

USE OF E/M CODES IN CONJUNCTION WITH SURGICAL DEBRIDEMENTS

- Patients who have chronic wounds may frequently 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.
- An E/M service provided and documented on the same day as a debridement service may be covered only 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 provided.
- Use an ICD-10 coding other than the ulcer coding, with a -25 modifier

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

- Not discussed in the LCD
- Refer to coverage provisions of LCD33821, Noridian DME

LOW-FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND

- System using low-frequency ultrasonic energy to produce and propel a mist of liquid and deliver continuous low-frequency ultrasound to the wound bed. “MIST” therapy
- Wounds /ulcers too painful for sharp or excisional debridement and have failed non-sharp conventional debridement (Non-Selective Debridement)
- Needs documented contraindications to sharp/excisional debridement
  - or Normal process of healing has not progressed as expected at 30 days
- Provided 2-3 x per week
- Observable improvements in the wound after 6 treatments

WHAT TO DOCUMENT FOR IMPROVEMENT OF WOUNDS

- Reduction of one or more of the following:
  - Pain
  - Necrotic tissue
  - Wound size
  - Wound depth
- Or Improvement in granulation tissue
- Or Improvement of infection

ADDITIONAL COMPRESSIVE TREATMENT

- Unna Boot (Paste Boot)
- Total Contact Casting
- Multi-Layer Compression System, helpful for venous ulcers

LIMITATIONS

ODDS AND ENDS AND OPINIONS BY AUTHORS

WOUND CARE INCLUDES, DOCUMENTATION OF

- Appropriate control of complicating factors
  - Unrelieved pressure
  - Infection
  - Vascular
  - Uncontrolled metabolic derangement
  - Nutritional deficiency
- Employ adjunctive measures to control the factors above

- Otherwise the debridement is not medically reasonable and necessary

DEBRIDEMENT REQUIREMENTS

- Debridement is not reasonable and necessary for a wound that is clean and free of:
  - Necrotic tissue
  - Slough
- Debridements considered selective or non-selective **unless** medical record supports that a **surgical** debridement was performed
- Debridements are best provided under an individualized Plan of Care
  - We must have a Plan of Care that covers all the control of complicating factors and the medical need for debridement with presence of necrotic tissue/ slough/etc

PALLIATIVE WOUND CARE

- Wound care may be of a palliative nature If the Goal is **not** wound healing
- Wounds in SNF or NF may not close, heal or be amenable to self-care in spite of optimal therapy
- Goals:
  - Minimizing risk of infection and further negative progression of the wound
  - Prevention of hospitalization
  - Managing the multiple issues that cause patient and family suffering
  - Optimizing the patient’s function and quality of life

PALLIATIVE WOUND CARE

- Document the complicating circumstances that support the additional wound care services as reasonable and necessary

CONTINUATION: LIMITATIONS

- Autolytic debridement is contradicted for infected wounds
- Debridement of extensive eczematous or infected skin is not appropriate for debridement of a localized amount of tissue normally associated with a circumscribed lesion. Examples of this: ulcers, furuncles and localized skin infections
- Unproven debridement methods are considered “investigational” and not reasonable and necessary
  - Unproven by valid scientific literature
  - ABN must be obtained
- With debridement, the dressing change is considered integral component of the service and not a separately covered service

CONTINUATION LIMITATIONS

- **Surgical** debridement is not reasonable and necessary when documentation indicates the wound is without:
  - Devitalized
  - Fibrotic
  - Nonviable
  - Infection
  - Necrosis
  - Foreign matter
  - Or if the wound has pink to red granulated tissue (100%)
- Expected: the frequency of debridement will decrease over time

NO PROGRESSION AS EXPECTED AFTER 30 DAYS

- May require a new approach
- Modification to the written Plan of Care (POC)
- Physician reassessment of underlying problems that inhibit wound healing:
  - Infection
  - Offloading
  - Biofilm
  - Metabolic
  - Nutritional
  - Vascular problems

WHAT DEFINES “NO PROGRESSION OF THE WOUND”

- This must be documented.

- No **improvement** of any of the following:
  - Pain
  - Necrotic tissue, devitalized tissue, slough, eschar, biofilm
  - Drainage
  - Infection, cellulitis, errythema
  - Wound size
  - Wound depth
  - or lack of Improved granulation tissue

LIMITATIONS

- Procedures performed for cosmetic reasons, or to prepare tissues for cosmetic procedures are statutorily excluded from coverage
- Local anesthetic infiltration, regional blocks or topical anesthetic are included in the reimbursement for wound care services

SERVICES NOT CONSIDERED REASONABLE AND NECESSARY DEBRIDEMENT SERVICES

- Removal of non-tissue integrated fibrin exudates, crusts, 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.
- Removal of necrotic tissue by cleansing or dry-to-dry dressing
- Washing bacterial or fungal debris from lesions
- Removal of secretions & coagulation serum from normal skin surrounding an ulcer
- Dressings of small or superficial lesions
- Paring or cutting of corns or non-plantar calluses
- I&D of abscess including paronychia, trimming or debridement of mycotic nails, avulsion of nail plates, acne surgery or destruction of warts

PROCEDURES INCLUDED IN E/M SERVICE

- Removal of necrotic tissue by cleansing and dressing, including wet or dry-to-dry dressing changes
- Cleansing and dressing small or superficial lesions
- Removal of coagulated serum from normal skin surrounding an ulcer

BIOFILM

- Biofilm
  - The decision making in the management of biofilm in the wound
  - Topical agents used in the treatment of biofilm
- Biofilm has been observed in some studies to impact the healing of over 60% of chronic wounds. Some authors rate it immediately behind vascular supply, medical co-morbidities, and the need for pressure reduction and offloading as a leading cause of delayed wound healing.
- Fundamental attention to wound bed preparation, cleaning and debridement are the cornerstones of biofilm management.

LIMITATIONS

- Jet therapy or wound irrigations should be used cautiously as maceration of surrounding tissue may hinder healing.
- Jet therapy and wound irrigation must be performed by skilled personnel in order to be considered reasonable & necessary
- Wet-to-dry dressings are noted to have limitations and should be used with discretion

EXPECTATIONS

- Medicare expects that with appropriate care:
  - Wound volume or surface dimension should decrease or
  - Wounds will optimally demonstrate granulation tissue
  - or The provider will document why, with explanation including comorbidities
- Debridements must be preformed judiciously and at appropriate intervals
- With no extenuating medical or surgical complications or setbacks, wound volume or surface dimension should decrease over time
- Wound care treatment plan is modified in the event appropriate healing is not achieved

PLAN OF CARE AND MEDICARE'S EXPECTATION

- Assurance of sufficient vascular perfusion to support wound healing
- Basic assessment of the patient's metabolic stability
- Adequacy of nutritional support

- Medicare allows 30 days from 1st encounter to organize and enter a comprehensive Plan of Care – POC into the patient record
  - MAINTAINED AND UPDATED AS NEEDED
  - Available to Medicare upon request
- Revise with Change of Condition AND every 30 days

PLAN OF CARE

- Failure to document expected healing after 30 days must result in a revision of the POC including:
  - Possibility of alternative treatment approaches
  - Or transition to alternative care settings
    - Multidisciplinary specialized wound center
- Patients with chronic wounds may be demonstrating manifestations of underlying chronic illness.
  - Follow up and coordination with other medical practitioners must be fully reflected in the chart

ASSURANCE OF SUFFICIENT VASCULAR PERFUSION

- Arterial
  - Non-invasive arterial studies
  - Arterial Doppler
  - ABI
  - Toe-brachial index
  - $TCpO_2$
  - Angiography – the gold standard
- Venous
  - Venous Duplex
  - Venous Doppler
  - Venography

ASSURANCE OF SUFFICIENT VASCULAR PERFUSION MEDICAL RECORD

- Must identify the testing modality chosen to assess vascular competence
- Explain that choice in the context of the patient's medical history
- Provide documentation of test results
- If the test reveals an impediment to arterial or venous circulation that is likely to exert a negative impact on wound healing and an expectation that partial or full relief if the impediment will benefit the healing process:
  - The medical record must provide documentation of the intervention performed to reduce the impediment to flow.
  - The immediate outcome relative to the pre-intervention status must be included
  - If intervention is deferred, must explain why the intervention was not clinically appropriate for the specific patient

ASSURANCE OF SUFFICIENT VASCULAR PERFUSION MEDICAL RECORD

- Arterial and venous circulation in the extremity must be confirmed within 30 days of the initial encounter and be included in the Treatment Plan - Plan of Care

- Once adequacy of vascular supply is established, it is anticipated that these studies need not be repeated unless there is a failure to achieve wound healing

- So if the wound is not responding, reorder the tests and document.

METABOLIC STABILITY / NUTRITIONAL SUPPORT

- Basic assessment to be included in the POC / Treatment Plan
- Expected parameters indicating metabolic stability
  - CBC
  - CMP components
    - Glucose
    - BUN
    - Creatinine (serum)
    - Albumin (serum)
  - CRP / ESR
  - Pre-albumin (serum)
  - Hemoglobin A_1C (serum)

METABOLIC STABILITY / NUTRITIONAL SUPPORT

- Patients who are not following the expected progression of wound healing:
  - Formal nutritional assessment
  - Use a standardized assessment such as the ASPEN criteria
- Newer assessment tools:
  - MEAL Scale: more applicable to outpatient status

LCD/LCA CODING GUIDELINES

ARTICLE- BILLING AND CODING: WOUND AND ULCER CARE

A58565

WOUND CARE

- Active wound care management
  - Selective (97597)
  - Non-Selective (97602)
- Surgical debridement
  - Most surgical specialists fall into this category
  - 11042 series

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- Dressings applied to the wound on the day of the service are part of the service and can not be billed separately
- CPT 97602 can not be billed same day as 97597/97598

97597 VS. 11043

- Codes 97597/97598/97602 can not be reported in conjunction with the 11043-11047 code series for the same wound
- Wound depth determines the code
- If only biofilm is debrided on the surface of a muscular ulceration, then use codes 97597/97598
- If the muscle substance is debrided, use codes 11043-11046

CODES 97602 / 97605 / 97606 / 97608

- Includes application of, and removal of, any protective devices or bulk dressings
- If dressing change is performed without any active wound procedure, then do not code with these CPT codes
  - E/M would be appropriate

WHIRLPOOL

- Component of CPT 97597 series. Not to be reported separately during the same encounter
- If there is a separate identifiable service being treated by the therapist, with documentation, then the service is considered for payment, with the -59 modifier (or more specific; LT, RT, -XS, etc)

SURGICAL DEBRIDEMENT 11042-11047, AND 11000-11012

- Dressings are part of the service and not to be billed separately
- Debridement of Necrotizing Soft Tissue Infections
  - CPT 11004-11006, and 11008
  - Inpatient only procedure codes
- Surgical Debridement – 11042-11046
  - Do not use –LT or –RT; the CPT is bilateral
  - Refers to size and levels of actual debridement.

SURGICAL DEBRIDEMENT 11042-11046

- Debridement of single wound
  - Report depth using the deepest level of tissue removed
  - Note the tissue removed in chart
- Debridement of multiple wounds
  - Sum the surface areas of wounds at the same depth
  - Do not combine wounds of different depths
  - Noridian allows for an aggregate total of multiple wounds as one independent tissue debridement on a given day of service

- Any number greater than the aggregate total of 4 for one or both feet per day of service will be denied; may be appealed with appropriate documentation justifying the additional services
- **Repeat debridements are not expected for several days after debridement**

SURGICAL DEBRIDEMENT 11042-11046 – CODE SELECTION

The CPT code selected should reflect the **level** of debrided tissue (e.g., skin, subcutaneous tissue, muscle and/or bone) not the extent, depth, or grade of the ulcer/wound

As an example: 11042, defined as debridement, subcutaneous tissue should be used if only necrotic subcutaneous tissue is debrided, even if the wound extends to the bone. If only fibrin is removed, this code would not be used

SURGICAL DEBRIDEMENT 11042-11046

- Debridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable.
  - However, debridement of tissue at the site of an open fracture or dislocation may be reported using CPT codes 11010-11012
- 11044: debridement and removal of bone. Bone must be removed.
  - Debridement “to bone”, without removal is coded as 11043
  - Pathology Report on the bone is recommended
- Document:
  - Type of tissue removed
  - Depth of wound
  - Size of wound
  - Other characteristics of the wound

E/M SERVICES
IN CONJUNCTION WITH DEBRIDEMENT

- Debridement surgical code includes the following on the day of service:
  - Pre-debridement wound assessment
  - The debridement
  - Post-debridement instructions provided to the patient/caregiver/nursing

MIST THERAPY

- 97610
- One service per day (usually two to three times per week)
- Not separately reportable on same day as Active Wound Management or Surgical Debridement

UNNA BOOT / TOTAL CONTACT CASTING

- Unna Boot: CPT 29580
- TCC: CPT 29445

- All supplies are included in the CPT code
- If both a debridement, and either Unna boot or TCC, occur on same day on the same anatomical area; only the debridement will be paid
- Debridement including removal of foreign material at site of open fracture is billable with the treatment of the fracture. The casting/ splinting/strapping code is not reported separately.

DOCUMENTATION REQUIREMENTS

WOUND DEBRIDEMENT ARTICLE

DOCUMENTATION

- All documentation maintained in the patients' medical records and must be made available upon request
- Every page must be legible and include
  - Patient identification
  - Legible signature of practitioner
- Document specific signs and symptoms supporting the wound care provided
  - Current status of the wound
  - Response to the current treatment

DOCUMENT PATIENT RESPONSE TO TREATMENT

- Progress of the wound at each visit
- Current wound volume
- Presence (and extent of) or absence of obvious signs of infection
- Presence (and extent of) or absence of necrotic, devitalized or non-viable tissue
- Other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown
- Wound location and stage/grade
- Photos are recommended

DEBRIDEMENT DOCUMENTATION

- When debrided, type of tissue removed during the procedure
- Post-debridement size and depth
- Bleeding and Hemostasis Used
- Pain
- Path report is encouraged for muscle or bone

DOCUMENTATION: GOALS

- Expectation that the treatment will:
  - Substantially affect tissue healing and viability
  - Reduce or control tissue infection
  - Remove necrotic tissue
  - Prepare the tissue for surgical management
- The extent and duration of wound care treatment must correlate with the patient's expected restoration potential
  - Compare the patient's progress to the POC
    - If slower than the POC projected, explain why

DOCUMENTATION: GOAL
WHEN CLOSURE IS NOT A REASONABLE GOAL
(PALLIATIVE WOUND CARE)

- Expectation #1:
  - To optimize recovery
  - Establish an appropriate non-skilled maintenance program

Or

- Expectation #2:
  - **Palliative Wound Care**

PALLIATIVE WOUND CARE: GOALS

- Diminish probability of prolonged hospitalization
- Reduce the number of hospitalizations
- Minimize infection
- Minimize pain
- Increase patient function to their maximum capability

- If it is determined that the goal of care is not wound closure, the patient should be managed following appropriate covered palliative care standards

OPERATIVE NOTE/PROCEDURE NOTE

- Medical diagnosis including al co-morbidities
- Indications and medical necessity for the debridement
- Type of anesthesia used, if and when. Note if not used
- Wound characteristics
  - Diameter
  - Depth
  - Undermining or tunneling (with measurements)
  - Color
  - Presence of exudates or necrotic tissue

OPERATIVE NOTE/PROCEDURE NOTE

- Level/depth of tissue debrided
- Description of the types of tissue involved in debridement and the tissues removed
- Vascular status, evidence of reduced circulation
- Infection
- Narrative of the procedure (see next slide)
- Patient specific goals and/or response to treatment
- Immediate post-op care and follow-up instructions
- Presence or absence of necrotic, devitalized, fibrotic, and/or other tissue or foreign matter

OPERATIVE NOTE: NARRATIVE

- Tissue removal:
  - Skin
  - Partial-thickness/full-thickness
  - Subcutaneous
  - Muscle and/or bone
- Method used to debride:
  - Sharp
  - Hydrostatic
  - Abrasion
  - Etc

OPERATIVE NOTE: NARRATIVE

- Characteristics of the wound before and after the debridement
- Dimensions before and after the debridement
- Degrees of epithelialization
- Description of necrotic matter, and slough, left after the debridement
- Refer to the POC or write in the narrative:
  - Complicating factors for wound healing (co-morbidities, contractures, activity limits
  - Measures taken to control the complicating factors
  - Modification of the treatment plan, when necessitated by failure of the wound to heal as predicted in the POC

DOCUMENTATION: NO IMPROVEMENT IN 30 DAYS

- Requires a new approach
- Physician assessment: of problems inhibiting wound healing
  - Non-compliance
  - Underlying infection
  - Metabolic
  - Nutritional
  - Vascular problems
    - Include edema
- Actions to deal with each of the problems inhibiting wound healing
- Or new treatment approach

DOCUMENTATION

- Appropriate evaluation and management of contributory medical conditions or other factors should be addressed in the medical record at intervals consistent with the nature of the condition or factor

- When the documentation, or lack of, does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity, the services will be denied as not reasonable or necessary

DOCUMENTATION:
JET TX AND MIST

- Documentation must support the use of skilled personnel with the use of jet therapy and wound irrigation for wound debridement
- Documentation of low frequency, non-contact, non-thermal ultrasound services (MIST) should include documented improvements of:
  - Pain reduction
  - Reduction in wound size
  - Granulation improved and increased
  - Reduction of necrotic tissue.
- The services should be medically necessary based on the provider's documentation of a medical evaluation of the patient's condition, diagnosis and plan

UTILIZATION GUIDELINES FOR DEBRIDEMENT

- The extent and number of services provided should be medically reasonable and necessary based on the documented medical evaluation of the patient's condition, diagnosis and plan

- Only a minority of patients who undergo debridements for wound care appear to require more than **12 total** excisional debridement involving the 11042-11047 in a **360 day** period.
  - **With only 5 debridements involving muscle/fascia and/or bone, in order to accomplish the desired objective of the treatment plan**

UTILIZATION GUIDELINES FOR DEBRIDEMENT

- If there is evidence of clear benefit from the debridements already provided
  - Debridement services may be continued beyond this frequency and time frame
  - Documented in medical records
  - Modified POC / treatment plan

- It is similarly unlikely that more than 4 debridements are needed in a month (30 days)
- Continuance of care depends on evidence of benefit to the patient