

Local Coverage Article: Wound Care & Debridement – Provided by a Therapist, Physician, NPP or as Incident-to Services (A53296)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	Guam Hawaii Northern Mariana Islands American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada American Samoa California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	Guam Hawaii Nevada Northern Mariana Islands

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Article Information

General Information

Article ID A53296	Original Article Effective Date 10/01/2015
Article Title Wound Care & Debridement – Provided by a Therapist, Physician, NPP or as Incident-to Services	Revision Effective Date 01/01/2017
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Article Guidance

Article Text:

This article clarifies wound care and debridement services provided by a therapist, physician, non-physician practitioner (NPP) or as incident-to services.

Medical Necessity

All Providers (including therapists) must document the medical necessity for all services provided. If there is no documented evidence (e.g., objective measurements) of ongoing significant benefit, then the medical record documentation must provide other clear evidence of medical necessity for treatments. The medical record must also clearly indicate the complexity of skills required by the treating practitioner/clinician.

Coding

Proper wound care coding requires careful reading of all Current Procedural Terminology (CPT) code descriptors and related CPT Manual instructions. Providers should note that some codes are per session or per wound surface area, not per wound or site.

Evaluation and Management (E/M) Coding Requirements

- *Only* physicians and NPPs (Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs) can provide and bill E/M and CPT 11000 series codes when the services are appropriate and state licensure allows. These services may not be provided as incident-to services by hospital staff.
- Services provided by qualified incident-to hospital staff, must meet both the incident-to service delivery requirements and the CPT descriptor requirements for the specific procedure.

*Note: For claims with dates of service prior to January 1, 2014: Hospitals may *bill* any E/M level within the *"established patient"* category that corresponds to the resources used in the provision of the covered 99211 service in the specific clinic. The charge must be the same for all patients. See the CMS manuals for additional billing instructions. Reference the Noridian article titled *"Incident To" Clarification for OPSS and CAH Outpatient* attached below for additional information.

For claims with dates of service on or after January 1, 2014: Hospitals may only bill HCPCS G0463. The charge must be the same for all patients. See the CMS manuals for additional billing instructions. Reference the Noridian article titled *"Incident to" Clarification for OPSS and CAH Outpatient* attached below for additional information.

Physical Medicine and Rehabilitation (PM&R) Codes (i.e. 97597, 97598, 97602)

- A physician, NPP or therapist acting within their scope of practice and licensure may provide debridement services and use the PM&R codes including CPT 97597, 97598 and 97602.
- These codes must only be billed for services that include medically necessary skilled debridement services.
- Hospital staff acting within their scope of practice and/or licensure may provide wound care, including debridement services, incident-to the services of a physician/NPP.
- Staff providing therapy services incident-to the physician treatment plan must meet the qualification guidelines established for auxiliary personnel as described in the IOM [Medicare Benefit Policy Manual](#), Publication 100-02,

Chapter 15, Sections 220(A), 230.5.

- CPT 97597, 97598, 97602 are considered "sometimes therapy" codes according to the IOM [Medicare Claims Processing Manual](#), Publication 100-04, Chapter 5, Section 20. As such, these treatment codes may be provided without a therapy plan of care by physician/NPPs or as incident-to services. When these "sometimes therapy" services are provided under a physician's/NPPs treatment plan they should be billed without a therapy modifier.
- When wound care services are delivered by therapists, there must be a physician certified therapy plan of care based on a thorough evaluation signed by the treating physician or NPP. The services must be billed using the appropriate therapy modifier and deliver within the CMS therapy guidelines found in the IOM [Medicare Benefit Policy Manual](#), Publication 100-02, Chapter 15, Sections 100 and 220-230.

Dressing Change

A dressing change may not be billed as either a debridement or other wound care service under any circumstance (e.g., CPT 97597, 97598, 97602).

- Medicare does not separately reimburse for dressing changes or patient/caregiver training in the care of the wound. These services are reimbursed as part of a billable E/M or procedure code that, commonly but not necessarily, occurs on the same date of service as the dressing change. If not included in another service, the costs associated with dressing changes may be reported as not separately payable.
- All topical applications (e.g. medications, ointments, and dressings) are included in the payment for the procedure codes.
- It is only appropriate to provide an Advance Beneficiary Notice of Noncoverage (ABN) for services that are anticipated to be denied due to the absence of medical necessity. An ABN for a dressing change is NOT appropriate since the costs of the dressing change are packaged into other procedures billed.

Evaluation/Re-assessment

In general, other than an initial evaluation, the assessment of the wound is an integral part of all wound care service codes and, as such, these assessments are not separately billable.

- Initial wound assessments that are medically necessary may be reimbursable as a separately identifiable Evaluation and Management (E/M) service or i.e., physical therapy initial evaluation CPT codes 97161-97163.

Note that CPT codes 97160-97163 are "always" therapy codes and the therapy modifier must be applied.

- Re-assessment/re-evaluation of a wound (which may be completed with a dressing change) is generally considered to be a non-covered routine service. An exception would require documentation clearly supporting that there had been a significant improvement, decline, or change in the patient's condition or functional status that was not anticipated in the plan of care and required further evaluation.
- The evaluation must be provided by a physician/NPP or therapist or other qualified incident-to hospital staff.
- Patients may be evaluated by the physician/NPP and the follow-up care may then be provided by qualified hospital incident-to staff working under the physician's plan of care. When a physical therapist provides these incident-to follow-up services and provides an initial therapy evaluation (CPT 97161-97163), the documentation must clearly indicate the medical necessity for these additional evaluative services (as compared to the previously completed physician evaluation of the patient's condition) in order to be separately reimbursable.
- An ABN may be given when medical necessity is not supported for the initial therapy evaluation. However, an ABN may not be given when medical necessity is not supported for a follow-up visit since there is no billable therapy code for a routine re-assessment (i.e. routine wound assessment with/without a dressing change).
- While a physician/NPP may not bill a new patient E/M with modifier 25 for any global service, the hospital may bill the E/M. See the IOM [Medicare Claims Processing Manual](#), Publication 100-04, Chapter 12, Section 40.3.

Debridement

Selective Debridement (CPTs 97597 and 97598) - Documentation to support selective debridement should include the following:

- Clear description of instruments used for debridement (i.e. high-pressure waterjet, scissors, scalpel, forceps).
- Thorough objective assessment of the wound including drainage, color, texture, temperature, vascularity, condition of surrounding tissue, and size of the area to be targeted for debridement

Non-Selective Debridement (CPT 97602) - Documentation to support non-selective debridement should include:

- Type of technique utilized i.e., wet-to-moist, enzymatic, abrasion.
- Thorough objective assessment of the wound as described in Selective Debridement above.

Whirlpool

- If the patient uses whirlpool for treatment of a wound prior to receiving selective debridement services for the wound *during the same visit*, then the whirlpool is not separately reimbursable and should not be billed with modifier 59 unless two separate wounds are treated with the different modalities.
- If the patient uses whirlpool for treatment of a wound prior to receiving non-selective debridement services for the wound *during the same visit*, then the whirlpool is separately reimbursable and may be billed with modifier 59.
- Whirlpool can also be completed *during the same visit* for non-wound care related purposes. It is appropriate to separately bill CPT 97022 when the whirlpool is used for other purposes not involving wound care i.e., facilitation of range of motion activities

Unna Boot Application

All supply items related to the Unna boot are inclusive in the reimbursement for CPT 29580.

High Compression Multi-Layered Bandage Systems

The application of the high compression bandage systems (i.e., Profore, Dyna-Flex, Surepress, Setopress, and other similar product systems) are used to primarily treat lymphedema and venous or stasis ulcers. Providers should note that the treatment of lymphedema with the application of high compression bandage systems continues to be non-covered by Medicare. However, a brief period of patient and/or caregiver education may be medically necessary and reimbursable. Noridian will cover and separately reimburse for the application training when Medicare coverage requirements are met. Further information may be found in the Noridian article titled [High Compression Bandage System Clarification](#).

Sources:

- *Current Procedural Terminology Assistant* - May 2002 "Active Wound Care Management;"
- *Current Procedural Terminology Manual*;
- IOM [Medicare Benefit Policy Manual](#) Publication 100-02, Chapter 15, Sections 100 and 220-230;
- IOM [Medicare Claims Processing Manual](#) Publication 100-04, Chapter 5, Sections 20 and 100.7 and [Chapter 12](#), Sections 30.6 and 40.3;
- National Corrective Coding Initiatives ([NCCI](#));
- Change Request [9782](#).

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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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply

equally to all claims.

N/A

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 article, 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 article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph:

29580
97022
97161
97162
97163
97597
97598
97602
G0463

Group 1 Codes: N/A

Group 1 CPT/HCPCS Code Group 1 CPT/HCPCS Code Description

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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[Revision History Information](#)

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R2	04/30/18 - Corrected the hyperlink to the <i>High Compression Bandage System Clarification</i> article.
01/01/2017	R1	Effective 01/01/2017 deleted CPT code 97001 and added 97161, 97162 and 97163 as replacement codes per CR 9782. Article also revised to combine JEA A53295 into the JEB A53296 so both JEA and JEB contract numbers will have the same final MCD Article number and link to Incident to Clarification for OPPS and CAH Outpatient

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A53287 - High Compression Bandage System Clarification](#) [A55215 - Incident To Clarification for OPPS and CAH Outpatient](#)

Related National Coverage Document(s) N/A

Statutory Requirements URL(s) N/A

Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

Other URL(s) N/A

Keywords

- Wound Care
- Debridement
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- Incident-to-Services
- 29580
- 97022
- 97161
- 97162
- 97163
- 97597
- 97598
- 97602
- G0463

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