Quality, Compliance and Reimbursement Manual

SerenaGroup

Building the Nation's Leading Wound Care Team

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MISSION STATEMENT

SerenaGroup© is committed to advancing the science and practice of wound healing by creating and sharing our wound care expertise. It is the intent and mission of these guidelines, to improve the quality of life of patients suffering from wounds that cause pain and threaten disability, loss of limb or life. These guidelines will encourage relationship-based care in a fiscally sound methodology.
The Wound Healing Team will provide a comprehensive multidisciplinary approach to wound care with efficient use of wound care products through a multidisciplinary, integrated team approach dedicated to the practice of modern wound healing and tissue repair. SerenaGroup© supports the center's mission of serving the health and wellness needs of the community with the latest evidence-based therapies and information on the management of acute and chronic wounds.

Compliance/Reimbursement Program Overview

SerenaGroup® (SG) stands behind its Compliance/Reimbursement Program. The program enhances patient care and assists business operations. It is our belief that the management team, employees and contractors will use these internal controls to more efficiently monitor and adhere to applicable statutes, regulations and Compliance Program requirements. The Compliance Program utilizes tools to assist all those conducting business on behalf of SerenaGroup© (SG) to comply with the laws and regulations affecting our business.

S/G's Compliance/Reimbursement Program consists of the following CORE elements:

1 Compliance Officer and Committee Oversight
2 Ownership of Ethical/Complaint behavior by all employees
3 Routinely monitor and audit practices/behavior/documentation and proactively address findings
4 Enforce and Educate standards in well published policies and procedures.

The above CORE elements serve as the foundation for all parties conducting business for and with our company. At the CORE, is our commitment to comply with federal, state and local healthcare rules and regulations, the importance and adherence to which cannot be overstated.

SG employees must be committed to the standards of conduct rooted in commitment, confidentiality and relationships, patient care, and maintaining business and professional integrity. Our team must recognize that they are accountable and have obligations to all persons and customers served: patients, physicians, client employees, and other healthcare professionals as well as the public. It is expected that SG's employees promote the dignity of the health care profession and are committed to conducting their activities as professionals with honesty, integrity and accountability, respecting all laws and refusing to participate in or conceal any unethical, false, fraudulent or deceptive activity.

Documentation, Billing, Coding and Reimbursement Guidelines:

Related to the Center for Medicare and Medicaid Services (CMS), The Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) code(s) may be subject to Correct Coding Initiative (CCI) edits. This information does not take precedence over CCI edits. Per CMS Medicare Learning Network (MLN) Medicare Matters number MM8863, the use of NCCI-associated modifiers should NOT be used to bypass a procedure-to-procedure (PTP) edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

All claims regardless of payer source must be coded utilizing the appropriate International Classification of Diseases (ICD) and the ICD-10-CM code that indicates the reason for the procedure. The ICD-10-CM code must be billed at the highest level of specificity for that code set. The ICD-10-CM code must be linked to the appropriate CPT code.

Advanced Wound Care

1. Wound care should employ comprehensive wound management including:
    a. appropriate control of complicating factors such as unrelieved pressure, infection, vascular and/or uncontrolled metabolic derangement, and/or nutritional deficiency in addition to appropriate debridement. Medicare/Insurers coverage for professional wound care procedures requires that all applicable adjunctive measures are also employed as part of comprehensive wound management.
2. Debridement will be considered not reasonable and necessary for a wound that is clean and free of necrotic tissue/slough.
3. Debridements are considered selective or non-selective unless the medical record supports that a surgical excisional debridement was performed.
4. Debridements are best provided under an individualized plan of care.
5. Wound care may be of a palliative nature: if it is determined that the goal of care is not wound healing that would lead ultimately to wound closure, **the patient should be managed following appropriate palliative care standards.** In patients where wound closure, healing, or self-care is not a likely outcome, the goals of wound care may include prevention of hospitalization and improvement in quality of life. As such, due to severe underlying debility or other factors, the goal of wound care provided in these settings may be only to prevent progression of the wound by stabilizing the wound by:
    1. minimizing the risk of infection and further progression of the wound.
    2. managing the multiple issues that cause patient and family suffering.
    3. optimizing the patient's function and quality of life.

    Complicating circumstances that support additional wound care services as reasonable and necessary must be supported by medical record documentation.

CPT Codes utilized in Wound Care

The below are considered **sometimes therapy CPT codes.** Therefore, they are not limited to any specialty if it is performed by a health care professional acting within his/her scope of practice and appropriate legal authority.

Selective Debridements

Selective or Non- Selective debridement procedures are performed to remove devitalized/ and or necrotic tissue to promote would healing. Debridement is the removal of foreign material and/or devitalized or contaminated tissue from or adjacent to a wound until surrounding healthy tissue is exposed. These debridements should be coded with CPT codes (97597, 97598, or 97602) unless the medical record supports a surgical debridement has been performed.

97597-SelectiveDebridement-Total wound area first 20 square centimeters.
97598- Selective Debridement-Total wound area > 20 square centimeters.
97602- Non-Selective Debridement- wound/session for on-going care per session.

NOTE- Typically dressings to include application and the removal of any protective or bulk dressings are included in payment and should not be billed separately.
It is not appropriate to report CPT code 97602 in addition to CPT code 97597 and/or 97598 for wound care performed on the same wound on the same date of service.
If only a dressing change is performed without any active wound procedure as described by these debridement codes, these codes should not be reported.
These CPT codes should not be reported in conjunction with code(s) 11042-11047.

An appropriate example of utilizing the above CPT codes would be:
If only biofilm on the surface of a muscular ulceration is debrided, then codes 97597-97598 would be appropriate.

Negative Pressure Wound Therapy

Negative Pressure Wound Therapy (NPWT**)** is the "application and utilization" of either durable or disposable medical equipment and a method of wound care to manage wound exudates and promote wound closure. The vacuum assisted drainage collection (i.e., NPWT) may be applied to cleanse the wound by removing fluids and stimulate the wound bed in order to reduce localized edema and improve local oxygen supply.

97605-Total wound surface area </= 50 square centimeters
97606-Total wound surface area > 50 square centimeters

NPWT for non-healing wounds is medically necessary when at least one of the following conditions is met:

1. Complications of a surgically created wound (e.g., dehiscence, post sternotomy disunion with exposed sternal bone, post sternotomy mediastinitis, or postoperative disunion of the abdominal wall).
2. Traumatic wound (e.g., preoperative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments).

3. Chronic, non-healing ulcer with lack of improvement despite standard wound therapy, including the application of dressings, debridement of necrotic tissue (if present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth) in ONE of the following clinical situations:

Subacute and dehisced wounds:

1. Traumatic wounds
2. Ulcers (such as diabetic or pressure)
3. Chronic Stage III or Stage IV pressure ulcer
4. Chronic diabetic neuropathic ulcer
5. Chronic venous ulcer
6. Flaps and grafts

NPWT is contraindicated for any of the following wound types/conditions:

1. Necrotic tissue with eschar present,
2. Untreated osteomyelitis,
3. Non-enteric and unexplored fistulas,
4. Malignancy in the wound,
5. Exposed vasculature,
6. Exposed nerves,
7. Exposed anastomotic site, or
8. Exposed organs.

Note: A diagnosis code supporting the therapy as well as a statement from the treating physician describing the initial condition of the wound, including measurements, and the efforts to address all aspects of wound care. The medical record must include updated wound measurements and what changes are applied to heal the wound at each weekly assessment. Month-to-month comparisons of wound size and quantitative measurements of wound characteristics must be available.

Low frequency, Non-contact, Non-Thermal Ultrasound (MIST Therapy)

Low frequency, non-contact, non-thermal, ultrasound, including topical application(s) when performed wound assessment and instructions(s) for ongoing care per day.

97610-per session/per day

Non-Contact, Non-Thermal Ultrasound (MIST Therapy) is considered reasonable and necessary wound therapy and therefore eligible for coverage when provided for any of the following clinical conditions: Wounds and ulcers which are too painful for sharp or excisional debridement and have failed conventional debridement. It may be provided two to three times per week to be considered reasonable and necessary. The length of individual treatments will vary per wound size.

However, observable, documented improvements in the wound(s) should be evident after six treatments and include documented reduction in pain, necrotic tissue, or wound size, or improved granulation tissue.

NOTE: CPT code 97610 one service per day is allowable for a qualifying wound. CPT Code 97610 is not separately reportable for treatment of the same wound on the same day as other active wound care management CPT codes (97597-97606) or wound debridement CPT codes (e.g., CPT codes 11042-11047, 97597, 97598).

Compression Therapy for Chronic Venous Leg Ulcers

Strapping: Application of Paste Boot- A compression dressing for varicose veins or ulcers consisting of a paste made of zinc oxide, gelatin, glycerin, and water that is applied to the lower leg, covered with a bandage, and then applied to the extremity for the management of venous leg ulcers and associated conditions.

29580-per extremity. If bilateral application, ensure appropriate modifier is utilized.

Application of Multi-Layered Compression Dressing system; leg (below knee), including ankle and foot. a multi-layer compression bandaging system developed to apply sustained graduated compression for the management of venous leg ulcers and associated conditions.

29581-per extremity. If bilateral application, ensure appropriate modifier is utilized.

NOTE: supply items related to the Unna boot or MLC are inclusive in the reimbursement for CPT code 29580 or 29581. When both a debridement is performed and a MLC or Boot is applied, only the debridement may be reimbursed. If only an Unna boot/MLC is applied and the wound is not debrided, then only the Unna boot/MLC application may be eligible for reimbursement.

Casting for Off-Loading

The application process includes management of the diabetic ulcer wound site, if present, along with the application of protective stockinet and dense padding layers over tibial, malleolar, foot and toe surfaces. This is followed by layers of plaster and fiberglass casting materials and splints for rigidity. Rigid support foot plate and walker heel or an external rigid splint boot is applied for ambulation.

29445- Application of rigid total contact leg cast

Debridements (Excisional) Surgical

Surgical Debridements are performed to surgically remove (debridement) devitalized tissue from wounds. 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 or wound.

11042- Subcutaneous tissue (including epidermis and dermis, if performed) first 20 square centimeters or less. NOTE-IF =/> 20 sq. cm. report with 11045

11045-Subcutaneous tissue each additional 20 square centimeters or part thereof. Must report with 11042.
11043- Muscle and/or fascia (includes above layers) first 20 square centimeters or less. NOTE-IF =/> 20 sq. cm report with 11046
11046- Muscle and/or fascia each additional 20 square centimeters or part thereof. Must report with 11043.
11044- Bone (includes above layers) first 20 square centimeters or less. NOTE-IF =/> 20 sq. cm. report with 11047
11047- Bone each additional 20 square centimeters or part thereof. Must report with 11044

The depth reported for a single wound is the deepest depth of tissue removed. When debridement at the same depth is performed on two or more wounds, the surface areas of wounds are combined. 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 or wound.
When the depth of debridement is not the same, the surface areas are not combined. What does this mean? If a patient has more than one wound and they are not the same (e.g. wound one has a depth of subcutaneous and wound four has a depth to muscle, they are reported separately with an appropriate modifier (59).

For all Surgical (Excisional) debridements the procedure note for the debridement service(s) must include the minimum following:

Medical Necessity/Indication for the debridement.
Type of anesthesia when used.
Wound characteristics such as diameter, depth, undermining or tunneling, color, presence of exudates or necrotic tissue epithelialization, etc.) before and after debridement.
Level/depth of tissue debrided and a description of the types(s) of tissue involved and the tissue(s) removed (i.e., skin, full or partial thickness; subcutaneous tissue; muscle and/or bone)
Vascular status, infection, or evidence of reduced circulation.
Instruments used
Patient goals and/or response to treatment.
Immediate post-op care and follow-up instructions.

The following services are considered not reasonable and necessary wound debridement services:

1. Removal of necrotic tissue by cleansing or dry-to-dry or wet-to-dry dressing.
2. Washing bacterial or fungal debris from lesions.
3. Removal of secretions and coagulation serum from normal skin surrounding an ulcer.
4. Dressing of small or superficial lesions.
5. Paring or cutting of corns or non-plantar calluses.
6. Incision and drainage of abscess including paronychia, trimming or debridement of mycotic nails, avulsion of nail plates, acne surgery, or destruction of warts.
7. 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.

NOTE: CPT codes 11042-11047 is not appropriate for the following services: washing bacterial or fungal debris from feet, paring or cutting of corns or calluses, incision and drainage of abscess including paronychia, trimming or debridement of nails, avulsion of nail plates, acne surgery, destruction of warts, or burn debridement.

Example of inappropriate use of CPT code 11042 (debridement, subcutaneous tissue) should be used if only necrotic subcutaneous tissue is debrided, even though the ulcer or wound might extend to the bone. In addition, if only fibrin is removed, this code would not be billed.

Evaluation and Management Codes are utilized to capture Resource Utilization (typically quantified by time) in the Wound Center when procedures are not performed. The appropriate E&M code is dependent on the payer; For example, the CMS utilizes one CPT code- G0634 for both new and established patients regardless of the time element.

99201/02/03/04/05- Evaluation and Management of new patient

99211/12/13/14/15- Evaluation and Management of an established patient that may or may not require the presence of a Physician or other Non-Physician Provider.

G0634- Hospital Outpatient Department visit for the assessment and management of a patient, (typically limited the CMS Medicare recipients).

NOTE: E&M codes are not usually billed in conjunction with a debridement procedure. When providing and billing surgical debridement, 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" 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.

NOTE: The National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services Chapter 4, section G states that debridement codes (11042-11047, 97597) should not be reported with codes 29580, 29581 for the same anatomic area.

Skin Substitutes, Cultured Tissue Product, Human Skin Equivalents

Surgical Preparation of Site
Surgical preparation for skin replacement surgery describes the initial services related to preparing a clean and viable wound surface for placement of an autograft, flap, skin substitute graft or for negative pressure wound therapy.

15002- Trunk/Arms/Legs first 100 square centimeters or 1% of body area of infants and children.
15003- Above each additional 100 square centimeters. Must be reported with above code.

15004- Face/Scalp. Eyelids/Mouth/Neck/Ears/Orbits/Genitalia/Hands/Feet and or Multiple Digits first 100 square centimeters or 1%of body area of infants and children.
15005- Above each additional 100 square centimeters. Must be reported with the above code.

NOTE: Repeat use of surgical preparation services in conjunction with skin substitute application codes will be considered not reasonable and necessary. It is expected that each wound will require the use of appropriate wound preparation code at least once at initiation of care prior to placement of the skin substitute graft.

Application of Cultured Tissue Products to Chronic Non-Healing Wounds
Skin Substitutes or Cellular or Tissue Based Products (CTPs) to certain wounds may afford a healing advantage over dressings and conservative treatments when these options appear insufficient to effect complete healing. The individual products will continue to be identified with a Level II Healthcare Common Procedure Coding System (HCPCS) supply code from the section of the manual entitled "Skin Substitutes" and will not be included in this manual. Please refer to manufacturer of product for the appropriate Q-Code.

Application of **High Cost** Cultured Tissue Products to Lower Extremity Chronic Non-Healing Wounds

15271-Trunk/Arms/Legs first 25 square centimeters or less of wound surface area.
15272- As above, each additional 25 square centimeters or part thereof. Must list with above code.

15273-Trunk/Arms/Legs- Total wound surface area =/> 100 square centimeters wound surface area. First 100 square centimeters.
15274- As above each additional 100 square centimeters. Must list with above code.
15275- Face/Scalp/Eyelids/Mouth/Neck/Ears/Orbits/Genitalia/Hands/Feet or multiple digits first 25 square centimeters or less of wound surface area.
15276- As above each additional 25 square centimeters. Must list with above code.

15277- Face/Scalp/Eyelids/Mouth/Neck/Ears/Orbits/Genitalia/Hands/Feet or multiple digits first 100 square centimeters or less of wound surface area.
15278- As above each additional 25 square centimeters. Must list with above code.

Application of **Low Cost** Cultured Tissue Products to Lower Extremity Chronic Non-Healing Wounds:

C5271-Trunk/Arms/Legs first 25 square centimeters or less of wound surface area.
C5272- As above, each additional 25 square centimeters or part thereof. Must list with above code.

C5273-Trunk/Arms/Legs- Total wound surface area =/> 100 square centimeters wound surface area. First 100 square centimeters.
C5274- As above each additional 100 square centimeters. Must list with above code.

C5275- Face/Scalp/Eyelids/Mouth/Neck/Ears/Orbits/Genitalia/Hands/Feet or multiple digits first 25 square centimeters or less of wound surface area.
C5276- As above each additional 25 square centimeters. Must list with above code.

C5277- Face/Scalp/Eyelids/Mouth/Neck/Ears/Orbits/Genitalia/Hands/Feet or multiple digits first 100 square centimeters or less of wound surface area.
C5278- As above each additional 25 square centimeters. Must list with above code.

Application Cultured Tissue Products to Lower Extremity Chronic Non-Healing Wounds

(DFU and VLU) will be covered when the following conditions are met for the individual patient:

Presence of neuropathic diabetic foot ulcer(s) having failed to respond to documented conservative wound-care measures of greater than four weeks, **during which the patient is compliant with recommendations,** and without evidence of underlying osteomyelitis or nidus of infection.

Presence of a venous stasis ulcer for at least 3 months but unresponsive to appropriate wound care for at least 30 days with documented compliance.

Presence of a full thickness skin loss ulcer that is the result of abscess, injury or trauma that has failed to respond to appropriate control of infection, foreign body, tumor resection, or other disease process for a period of 4 weeks or longer.

The ulcer must be free of infection and underlying osteomyelitis with documentation of the conditions that have been treated and resolved prior to the institution of skin substitute therapy. Documentation of appropriate conservative therapy includes:

Control of edema, venous hypertension or lymphedema.

Control of any nidus of infection or colonization with bacterial or fungal elements.

Elimination of underlying cellulitis, osteomyelitis, foreign body, or malignant process.

Appropriate debridement of necrotic tissue or foreign body (exposed bone or tendon).

For diabetic foot ulcers, appropriate non-weight bearing or off-loading pressure.

For venous stasis ulcers, compression therapy provided with documented diligent use of multilayer dressings, compression stockings of greater than 20mmHg pressure, or pneumatic compression.

Provision of wound environment to promote healing (protection from trauma and contaminants, elimination of inciting or aggravating processes).

Documentation of smoking cessation counseling and cessation measures prescribed, if applicable, must also be documented in the patient's record.

The selected ICD-10-CM code(s) must meet Medical Necessity and the submitted CPT/HCPCS code must describe the service performed.

The medical record must clearly show that the criteria listed under the Covered Indications and Limitations sections have been met, as well as, the appropriate diagnosis and response to treatment.

The documentation must support the need for skin substitute application and the product used.

A description of the wound(s) must be documented at baseline (prior to beginning conservative treatment) relative to size, location, stage, duration, and presence of infection, in addition to type

of treatment given and response. And, information must be updated in the medical record throughout treatment.
Wound description must also be documented pre- and post-treatment with the skin substitute graft being used.

For each Application all the Procedure Note must clearly document must be maintained in the patient's medical record and must include:

Amount utilized and wasted skin substitute.
Date, time and location of ulcer treated.
Name of skin substitute and how product supplied.
Amount of product unit used.
Amount of product unit discarded.
Reason for the wastage.
Manufacturer's serial/lot/batch or other unit identification number of graft material. When manufacturer does not supply unit identification, record must document same.

NOTE: If obvious signs of worsening or lack of treatment response is noted, continuing treatment with the skin substitute would not be considered medically reasonable and necessary without documentation of a reasonable rationale for doing so.
NOTE: Medicare and most payers cover application of skin substitutes to Ulcers or Wounds with **Failed Response** that are: Partial- or full-thickness ulcers, not involving tendon, muscle, joint capsule or exhibiting exposed bone or sinus tracts, with a clean granular base; **Skin deficit at least 1.0 cm² in size**; Clean and free of necrotic debris or exudate; Have adequate circulation/oxygenation to support tissue growth/wound healing as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30mm Hg); For diabetic foot ulcers, the patient's medical record reflects a diagnosis of Type 1 or Type 2 Diabetes and also reflects medical management for this condition.

NOTE: Some CMS MACS require that when billing for Part B drugs and biologicals (except those provided under Competitive Acquisition Program [CAP] for Part B drugs and biologicals), the use of the JW modifier to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded is required. The discarded amount shall be billed on a separate claim line using the JW modifier. Providers are required to document the discarded drug or biological in the patient's medical record.

Modifiers associated with Application of CTP's

The following are considered not reasonable and necessary and therefore will be denied:

Due to the propensity for misuse of skin substitute and biological dressing products, reimbursement may be made only when the medical record clearly documents that these products have been used in a comprehensive, organized wound management program. **All listed products, unless they are specifically FDA-labeled or cleared for use in the types of wounds being treated, will be considered to be biologic dressings and part of the relevant Evaluation and Management (E/M) service provided and not separately reimbursed.**

- Partial thickness loss with the retention of epithelial appendages is not a candidate for grafting or replacement, as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting.
- Skin substitute grafts will be allowed for the episode of wound care in compliance with FDA guidelines for the specific product (see utilization guidelines) not to exceed **10 applications** or treatments. In situations where more than one specific product is used, it is expected that the number of applications or treatments will still not exceed 10.
- Simultaneous use of more than one product for the episode of wound is not covered. **Product change within the episode of wound is allowed, not to exceed the 10-application limit per wound per 12-week period of care.**
- Treatment of any chronic skin wound will typically last no more than twelve (12) weeks.
- Repeat or alternative applications of skin substitute grafts are not considered medically reasonable and necessary when a previous full course of applications was unsuccessful. Unsuccessful treatment is defined as increase in size or depth of an ulcer or no change in baseline size or depth and no sign of improvement or indication that improvement is likely (such as granulation, epithelialization or progress towards closing) for a period of 4 weeks past start of therapy.
- Retreatment of healed ulcers, those showing greater than 75% size reduction and smaller than .5 sq.cm, is not considered medically reasonable and necessary.
- Skin substitute grafts are contraindicated and are not considered reasonable and necessary in patients with inadequate control of underlying conditions or exacerbating factors (e.g., uncontrolled diabetes, active infection, and active Charcot arthropathy of the ulcer extremity, vasculitis or continued tobacco smoking without physician attempt to effect smoking cessation).
- Skin substitute grafts are contraindicated in patients with known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, equine products).
- **Re-treatment within one (1) year of any given course of skin substitute treatment for a venous stasis ulcer or (diabetic) neuropathic foot ulcer is considered treatment failure and does not meet reasonable and necessary criteria for re-treatment of that ulcer with a skin substitute procedure.**

Hyperbaric Oxygen Therapy

G0277-HBOT Full Body Chamber 30 minutes (unit) Typically four units billed for a standard wound care treatment (Facility component billed by the facility for equipment and resource utilization.

A modality in which the ***entire body is exposed to oxygen under increased atmospheric pressure***. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere pressure. Either a mono-place chamber pressurized with pure O_2 or a larger multi-place chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

99183-Hyperbaric Oxygen Therapy (Professional component, billed by provider medically supervising and overseeing the treatment.

*Immediate availability requires the immediate physician presence of the supervisory physician**. For services furnished on-campus, the supervisory physician may not be so physically distant from the location where the hospital/CAH or outpatient services are being furnished that he or she could not intervene right away.** A supervisory physician may furnish direct supervision from a*

physician office or other nonhospital space that is not physically part of the hospital campus where the service is being furnished as long as he remains immediately available. Similarly, an allowed practitioner can furnish direct supervision from any location in or near an off-campus hospital or CAH building that houses multiple hospital provider-based departments where the services are being furnished as long as the supervisory practitioner is immediately available.

In order to satisfy the immediately available criteria, for HBO therapy performed in an outpatient hospital, on-campus or off campus provider-based department, the physician (or qualified NPP) must be present in the office suite or at a location with ***a maximum of a five (5) minute response time to the chamber****. For HBO performed in a physician office, the physician (or qualified NPP) must be present in the office suite.*

HYPERBARIC OXYGEN therapy serves four primary functions:

Increases the concentration of dissolved OXYGEN in the blood, which augments oxygenation to all parts of the body;
Replaces inert gas in the bloodstream with OXYGEN, which is then metabolized by the body and
May stimulate the formation of a collagen matrix and angiogenesis and
Acts as a bactericide for certain susceptible bacteria.

Below are the two-established list of diagnosis that meet Medical Necessity.

<u>Center for Medicare and Medicaid Services Approved Indication List (as published in NCD 20.29)</u>

1. Acute carbon monoxide intoxication,
2. Decompression illness,
3. Gas embolism,
4. Gas gangrene,
5. Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened.
6. Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.
7. Progressive necrotizing infections (necrotizing fasciitis),
8. Acute peripheral arterial insufficiency,
9. Preparation and preservation of compromised skin grafts (not for primary management of wounds),
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management,
11. Osteoradionecrosis as an adjunct to conventional treatment,
12. Soft tissue radionecrosis as an adjunct to conventional treatment,
13. Cyanide poisoning,
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment,
15. Diabetic wounds of the lower extremities in patients who meet the following three criteria:

Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;

Patient has a wound classified as Wagner grade III or higher; and
Patient has failed an adequate course of standard wound therapy.

Undersea and Hyperbaric Medical Society Approved List (as listed in the UHMS Hyperbaric Oxygen Therapy Indications 13th Edition)

1. Air or Gas Embolism
2. Arterial Insufficiency
    1. Central Retinal Artery Occlusion
    2. Enhancement of selected Problem Wounds
3. Carbon Monoxide Poisoning
4. Clostridal Myonecrosis (Gas Gangrene)
5. Compromised Grafts and Flaps
6. Crush Injuries and Skeletal Muscle-Compartment Syndromes
7. Decompression Sickness
8. Delayed Radiation Injuries (Soft Tissue and Bony Necrosis)
9. Idiopathic Sudden Sensorineural Hearing Loss
10. Intracranial Abscess
11. Necrotizing Soft Tissue Infections
12. Refractory Osteomyelitis
13. Severe Anemia
14. Thermal Burns

1. The selected ICD-10-CM codes must meet Medical Necessity and the submitted CPT/HCPCS code must describe the service performed.
2. The medical record documentation must support the medical necessity of the services as directed in this policy.
3. Documentation that a trained emergency response team is available and that the setting provides the required availability of ICU services that could be needed to ensure the patient's safety if a complication occurred.
4. The documentation present in the clinical record must provide an accurate description and diagnosis of the medical condition supporting that the use of HBO is reasonable and medically necessary. The medical documentation must include but is not limited to the following:
    a. An initial assessment, which includes a history and physical that clearly substantiates the condition for which HBO is recommended. This should also include any prior medical, surgical or HBO treatments.
    b. Documentation of the procedure (logs) including ascent time, descent time and pressurization level. There should be a treatment plan identifying timeline and treatment goals.
    c. Physicians' progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received and the assessment of the level of progress made toward achieving the completion of established therapy goals.
    d. Physician-to-physician communications or records of consultations, additional assessments, recommendations or procedural reports.
    e. Laboratory reports (cultures or Gram stains) that confirm the diagnosis of necrotizing fasciitis are required and must be present as support for payment of HBO.

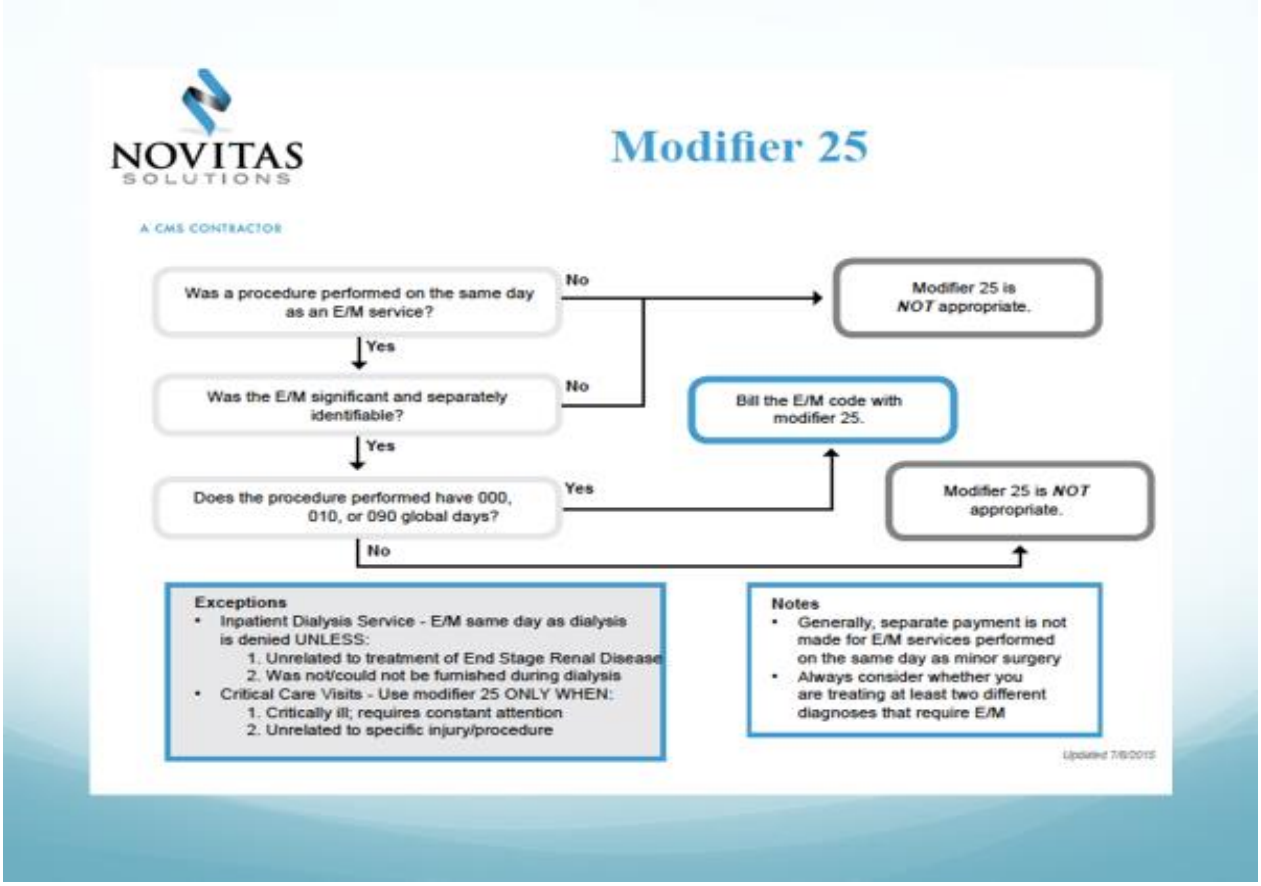
f. X-ray findings and bone cultures confirming the diagnosis of osteomyelitis are required and must be present as support for payment of HBO
g. Documentation to support the presence of gas gangrene as proven with laboratory reports (Gram stain or cultures) and X-ray.
h. Documentation of date and anatomical site of prior radiation treatments.
i. Documentation supporting date of skin graft and compromised state of graft site.
j. For diabetic wounds of the lower extremity, the Wagner classification of the wound and the failure of an adequate course (at least 30 days) of standard wound therapy must be documented at the initiation of therapy:
    i. Documentation must include criteria and exam consistency to establish the diagnosis of a Wagner's grade III wound.
    ii. Documentation of standard wound care in patients with diabetic wounds must include:
        1. Assessment of a patient's vascular status and documentation of correction of any vascular problem sufficient to impair wound healing in the affected limb.
        2. Documentation of optimization of nutritional status and glucose control
        3. Documentation of smoking cessation education
        4. Documentation of debridement by any means to remove devitalized tissue.
        5. Documentation of maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings.
        6. Documentation of efforts for appropriate off-loading.
        7. Documentation of necessary treatment to resolve any infection that might be present.

NOTE: Failure to respond to standard wound care occurs when there is no documentation of measurable signs of healing for at least 30 consecutive days post optimization for healing. The medical record must include, at a minimum, a wound evaluation at least every 30 days during administration of HBO therapy.

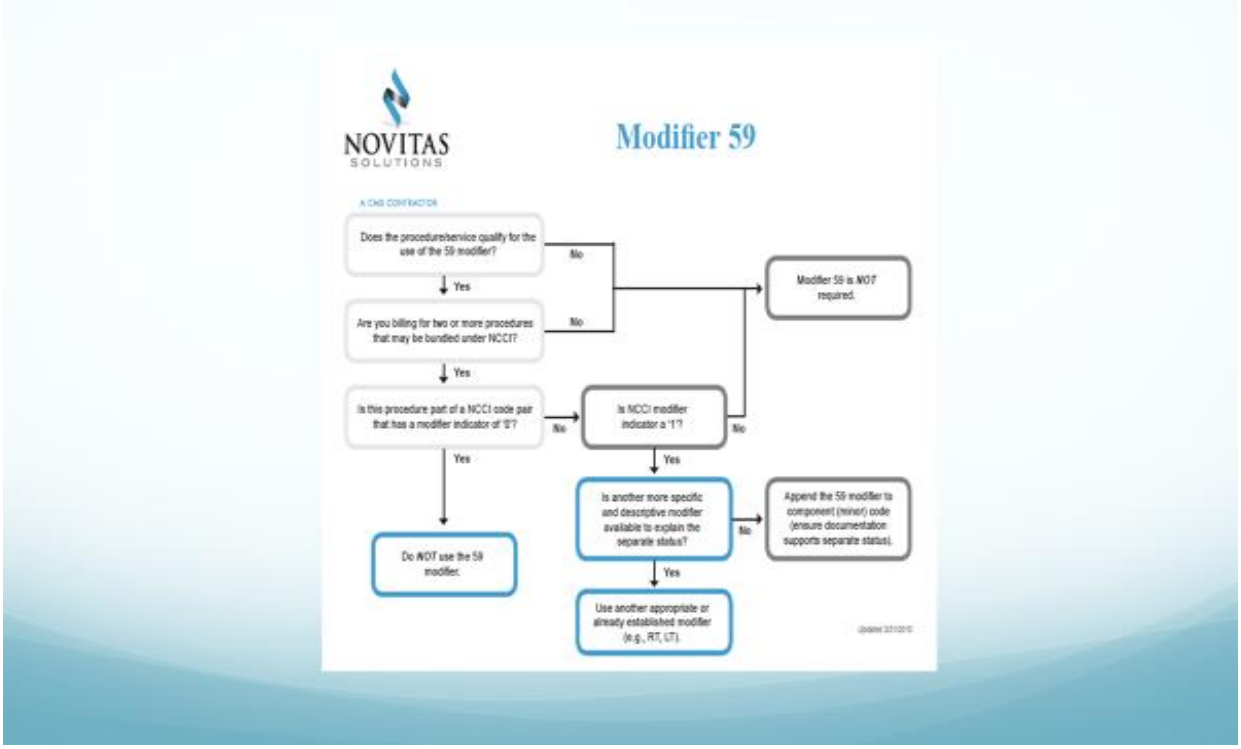
MODIFIERS

Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service in order to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits. Some modifiers cause automated pricing changes, while others are used for information only. When selecting the appropriate modifier to report on your claim, please ensure that it is valid for the date of service billed.

25-defined as a significant, separately identifiable E/M *(evaluation and management)* service by the same physician or other health qualified health care professional on the same day of a procedure or other service.



59-Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M *(evaluation and management)* services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.



Modifiers XE, XS, XP, XU defined

XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.

XS – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”

XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”

XU – “Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service”

Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, you may begin using them for claims with dates of service on or after January 1, 2015.

Note: You have the option to continue using modifier 59 in any instance in which it was correctly used prior to January 1, 2015. CMS' additional guidance and education as to the appropriate use of the new -X modifiers are forthcoming.

50- Bilateral procedure

Side of Body Modifiers.

RT-Right

LT- Left

How to code and bill bilateral procedures correctly:

Report one-line appending modifier 50 using one unit of service

Providers can bill the RT & LT modifiers in lieu of the modifier 50.

Report one-line appending modifiers RT and LT using two units of service

Report two lines using modifiers RT and LT with one unit of service on each line.

HOW TO USE THE MEDICARE NATIONAL CORRECT CODING INITIATIVE (NCCI) TOOLS- Appendix A

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. **NCCI Procedure-to-Procedure (PTP) code pair edits** are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. In addition to PTP code pair edits, the NCCI includes a set of edits known as **Medically Unlikely Edits (MUEs)**. An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a **single** Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

NOTE: The below and attached appendix is for reference only. All issues encountered with NCCI edits at the Program Director Level that are not able to addressed, must be discussed with the Chief Quality Officer or other Corporate Reimbursement individual. Typically, confusion comes addressing what can/cannot be billed together, what can/cannot be unbundled and what modifier, if appropriate may/must/should be utilized.

Accurate coding and reporting is imperative and serves a critical element of billing for Medicare services.

NCCI Tables are updated quarterly and can be found on the CMS NCCI website page: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Important Terms:

Procedure to Procedure (PTP)-are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

Medically Unlikely Edits (MUE)-is a maximum number of Units of Service (UOS) allowable under most circumstances for a **single** Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

PTP Edits-Hospital- This set of PTP code pair edits is applied to the following Types of Bills (TOBs) subject to the **Outpatient Code Editor (OCE):** Hospitals (TOB 12X and 13X), Skilled Nursing Facilities (SNFs) (TOB 22X and 23X), Home Health Agencies (HHAs) Part B (TOB 34X), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs) (74X), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75X).

Facility Outpatient MUEs-These edits are applied to all claims for TOB 13X, 14X, and Critical Access Hospitals (CAHs) [85X].

PTP edits files typically utilized in Advanced Wound Care are found in Tables 10000-19999 Surgery (Integumentary System), 90000-99999 Medicine Evaluation and Management Services, 20000-29999 Surgery (Musculoskeletal System) and A0000-V9999 Supplemental Services.

ADVANCE BENEFICIARY NOTICE- Appendix B

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.

You must issue an ABN:

- When an item or service is not considered reasonable and necessary under Medicare Program standards. Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
  - Experimental and investigational or considered “research only”.
  - Not indicated for diagnosis and/or treatment in this case.
  - Not considered safe and effective.
  - More than the number of services Medicare allows in a specific period for the corresponding diagnosis.

APPROVED SERENA GROUP SUPER BILL (CHARGE TICKET) Appendix C

In the event your facility is utilizing a hard copy (paper) process, only the approved Serena Group Super Bill may be used.

Appendix A: Advance Beneficiary Notice of Noncoverage (ABN)

Form Instructions

Advance Beneficiary Notice of Noncoverage (ABN) OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. Since 2013, home health agencies (HHAs) providing care under Part A or Part B issue the ABN instead of the Home Health Advance Beneficiary Notice (HHABN) Option Box 1 to inform beneficiaries of potential liability. The HHABN has been discontinued.

All of the aforementioned physicians, suppliers, practitioners, and providers must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required; however, these facilities must use the ABN for Part B items and services.

The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must *retain a copy of the ABN delivered to the beneficiary* on file.

The ABN may also be used to provide voluntary notification of financial liability for items or services that Medicare never covers. When the ABN is used as a voluntary notice, the beneficiary doesn't choose an option box or sign the notice. CMS has issued detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual (MCPM), Publication 100-04, Chapter 30, §50. Related policies on billing and coding of claims, as well as coverage determinations, are found elsewhere in the CMS manual system or website: www.cms.gov.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. With the 2016 PRA submission, a non-substantive change has been made to the ABN. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has

been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.

Completing the Notice

ABNs may be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html . Notices should be used as is since the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned in these instructions and the on-line manual instructions for those choosing to integrate the ABN into other automated business processes. Instructions for completion of the form are set forth below:

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

Sections and Blanks:

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that notifiers remove the lettering labels from the blanks before issuing the ABN to beneficiaries. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into all of the blanks labeled (D) within the Option Box section, Blank (G). One of the check boxes in the Option Box section, Blank (G), must be selected by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre- printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

Body

Blank (D): The following descriptors may be used in the Blank (D) fields:

Item Service
Laboratory test Test
Procedure Care Equipment

The notifier must list the specific names of the items or services believed to be noncovered in the column directly under the header of Blank (D).

In the case of partial denials, notifiers must list in the column under Blank (D) the excess component(s) of the item or service for which denial is expected.

For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.*7.1 (b) of the MCPM, Chapter 30* for additional information.

General descriptions of specifically grouped supplies are permitted in this column.

For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.

When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN. Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as "Item(s)/Service(s)" is used. All Blank
(D) fields must be completed on the ABN in order for the notice to be considered valid.

Blank (E) Reason Medicare May Not Pay: In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

"Medicare does not pay for this test for your condition."
"Medicare does not pay for this test as often as this (denied as too frequent)."

"Medicare does not pay for experimental or research use tests."
To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D) when appropriate.
Blank (F) Estimated Cost: Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.
Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:
For a service that costs $250:
• Any dollar estimate equal to or greater than $150

• "Between $150-300"
• "No more than $500"

For a service that costs $500:
• Any dollar estimate equal to or greater than $375

• "Between $400-600"
• "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices,but the beneficiary would have the option of signing the ABN and accepting liability in these situations.
CMS will work with its contractors to ensure consistency when evaluating cost estimatesand determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

Options

Blank (G) Options: Blank (G) contains the following three options:

☐ **OPTION 1.** I want the (D) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays ordeductibles.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. See Ch. 30, §50.15.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare. Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under *"***D. Additional Information**.*"*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

☐ **OPTION 2.** I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare isnot billed.**

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

☐ **OPTION 3**. I don't want the (D)listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided*;* thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for

example: “beneficiary refused to choose an option.”

Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;

Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;

An additional dated witness signature; or Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

Special guidance ONLY for non-participating suppliers and providers (those who don’t accept Medicare assignment):

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: If Medicare does pay, you will refund any payments I made to you, less co- pays or deductibles.

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN.

The sentence must be stricken and can’t be entirely concealed or deleted.

There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier shall include the following CMS-approved unassigned claim statement in the (H) Additional Information section.

“This supplier doesn’t accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier’s charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier’s charge.”

- This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.

• An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the “Additional Information” section, the last sentence in Option 1 should be stricken.

B. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. ☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**. ☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: **AltFormatRequest@cms.hhs.gov.**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notificante:

B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.**_____ a continuación, usted deberá pagar. Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados. Prevemos que Medicare no pagará **D.**__ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D. mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **OPCIÓN 1.** Quiero **D.**_____ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.**_____ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago. **No tengo derecho a apelar si no se le cobra a Medicare.**

☐ **OPCIÓN 3.** No quiero **D.**_____ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633- 4227/**TTY**: 1-877-486-2048).

Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, por favor **llame al: 1-800-MEDICARE o escriba al correo electrónico**: **AltFormatRequest@cms.hhs.gov**.

Appendix B: Medicare National Correct Coding Initiative Tools

HOW TO USE THE MEDICARE NATIONAL CORRECT CODING INITIATIVE (NCCI) TOOLS

Target Audience: The information in this publication applies to all health care professionals and health care organizations. Also, any use of the pronoun "you" refers to the health care professional.
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

To Learn More…

If you find this How To booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the MLN Publications page at http://go.cms.gov/mln-publications and search for items containing the words "how to."

INTRODUCTION

WHAT IS THE MEDICARE NATIONAL CORRECT CODING INITIATIVE (NCCI)?

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. **NCCI Procedure-to-Procedure (PTP) code pair edits** are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.
In addition to PTP code pair edits, the NCCI includes a set of edits known as **Medically Unlikely Edits (MUEs)**. An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a **single** Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools
MLN Booklet
For information about the Medicaid NCCI program, refer to The National Correct Coding Initiative in Medicaid webpage at https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html.

To Learn More...

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

If you find this How To booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the MLN Publications page at http://go.cms.gov/mln-publications and search for items containing the words "how to."

WHY WOULD A HEALTH CARE PROFESSIONAL, SUPPLIER, OR PROVIDER USE THE NCCI WEBPAGE, TABLES AND MANUAL?

Accurate coding and reporting of services are critical aspects of proper billing. Service that is denied based on PTP code pair edits or MUEs may not be billed to Medicare beneficiaries; a provider cannot utilize an Advance Beneficiary Notice of Noncoverage (ABN) to seek payment from a Medicare beneficiary. The NCCI tools found on the Centers for Medicare & Medicaid Services (CMS) website (including the "National Correct Coding Initiative Policy Manual for Medicare Services") help providers avoid coding and billing errors and subsequent payment denials.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Should providers determine that claims have been coded incorrectly, they are responsible to contact their Medicare Administrative Contractor (MAC) about potential payment adjustments.

HOW UP-TO-DATE ARE THE NCCI TABLES?

The tables are updated quarterly and loaded into the Medicare claims payment processing systems and onto the CMS NCCI webpages.

Click the Quarterly PTP and MUE Version Update Changes link in the menu on the top left side of the National Correct Coding Initiative Edits webpage at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html to find quarterly changes to the Column 1/Column 2 and MUE tables. Additions, deletions, and revisions to the tables can be accessed under the Related Links section at the bottom of the page.

The "National Correct Coding Initiative Policy Manual for Medicare Services" is updated annually.

HOW TO LOCATE THE NCCI TABLES AND MANUAL

The PTP code pair edits, MUE tables, and NCCI manual are accessed through the National Correct Coding Initiative Edits webpage at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

Links to the PTP Coding Edits and Medically Unlikely Edits webpages are provided in the menu on the top left side of the National Correct Coding Initiative Edits webpage. Scroll to the Downloads section at the bottom of the National Correct Coding Initiative Edits webpage to find a link to the NCCI manual.

BACKGROUND: NCCI EDITS

The NCCI is comprised of two provider-type choices of PTP code pair edits and three provider-type choicesof MUEs:

PTP Code Pair Edits

1. **PTP Edits-Practitioners**These PTP code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Center (ASCs).
2. **PTP Edits-Hospital**This set of PTP code pair edits is applied to the following Types of Bills (TOBs) subject to the Outpatient Code Editor (OCE): Hospitals (TOB 12X and 13X), Skilled Nursing Facilities (SNFs) (TOB 22X and 23X), Home Health Agencies (HHAs) Part B (TOB 34X), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs) (74X), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75X).

MUEs

1. **Practitioner MUEs**These edits are applied to all claims submitted by physicians and other practitioners.
2. **Durable Medical Equipment (DME) Supplier MUEs**These edits are applied to claims submitted to DME MACs. (At this time, this file will include HCPCS A-B and E-V codes in addition to HCPCS codes under the DME MAC jurisdiction.)
3. **Facility Outpatient MUEs**These edits are applied to all claims for TOB 13X, 14X, and Critical Access Hospitals (CAHs) [85X].

Coding decisions for edits are based on conventions defined in the American Medical Association's (AMA's) "CPT Manual," national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Prior to the implementation of MUEs, the proposed edits are released for review and comment to the AMA, national medical/surgical societies, and other national health care organizations, including non-physician professional societies, hospital organizations, laboratory organizations, and durable medical equipment organizations. Similarly, proposed PTP code pair edits are released to various national health care organizations for review and comment prior to implementation.

USING THE NCCI TOOLS

LOOKING UP PTP CODE PAIR EDITS

The first step in looking up an edit is to click the PTP Coding Edits link in the menu on the left side of the National Correct Coding Initiative Edits webpage on the CMS website.

Figure 1 shows the screen after selecting PTP Coding Edits. Scroll to the Related Links section at the bottom of the page to find links to two Hospital PTP Edits tables and two Practitioner PTP Edits tables. We will refer to the tables as Hospital PTP Edits Table 1, Hospital PTP Edits Table 2, Hospital PTP Edits Table 3, Hospital PTP Edits Table 4, Practitioner PTP Edits Table 1, Practitioner PTP Edits Table 2, Practitioner PTP Edits Table 3, and Practitioner PTP Edits Table 4 in this booklet.

The names of the Hospital PTP Edits or Practitioner PTP Edits indicate the range of edits listed in the table, beginning with the first Column 1 or Column 2 code edit in the file and ending with the last Column 1 or Column 2 code edit in the file. Column 1 CPT codes, which end with letters M, U, or T, appear in the first table for both Hospital PTP Edits and Practitioner PTP Edits. Column 1 HCPCS Level II codes, which begin with letters A-V appear in the last table for both Hospital PTP Edits and Practitioner PTP Edits.

Click on the Hospital PTP Edits or Practitioner PTP Edits table you wish to view or save.

A license agreement will appear. To continue to the table selected, the terms and conditions of the AMA copyright must be accepted.

The tables can be opened in Microsoft Excel (the file ending in xlsx) or text file format. Click on the format you want to open the table.

Code Ranges

The following HCPCS/CPT code ranges can be found in the tables:

- 00000-09999: Anesthesia Services
- 10000-19999: Surgery (Integumentary System)
- 20000-29999: Surgery (Musculoskeletal System)
- 30000-39999: Surgery (Respiratory, Cardiovascular, Hemic and Lymphatic Systems)
- 40000-49999: Surgery (Digestive System)
- 50000-59999: Surgery (Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems)
- 60000-69999: Surgery (Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems)
- 70000-79999: Radiology Services
- 80000-89999: Pathology/Laboratory Services
- 90000-99999: Medicine, Evaluation and Management Services
- A0000-V9999: Supplemental Services
- 0001T-0999T: Category III Codes
- 0001M-0010M: MAAA Codes
- 0001U-0034U: PLA Codes

HELPFUL HINT

The files are zipped due to their size, which allows for faster download. If the files do not automatically unzip, you may need the appropriate software to unzip these files. If you scroll to the bottom of the PTP Coding Edits page and click on Help with File Formats and Plug-Ins, you can download free software. Remember that NCCI tables are updated quarterly and saved tables must be replaced in order to have the most current information.

HOW TO USE THE PTP CODE PAIR TABLES

We will demonstrate how to use the PTP code pair tables, using code 99215 and two of the four Practitioner PTP Edits tables as our examples. Our examples using the Practitioner PTP Edits tables and code 99215 will show:

How To Use The Column 1/Column 2 Tables To Determine:

. When is a code the reimbursable code of a PTP code pair?

. How do you identify all PTP code pairs when a code is not reimbursable or when it is only reimbursable if an appropriate modifier is used?

. When an appropriate modifier may be used.

What are the Column 1/Column 2 PTP Code Pair Tables?

Although the Column 2 code is often a component of a more comprehensive Column 1 code, this relationship is not true for many edits. In the latter type of edit, the PTP code pair edit simply represents two codes that should not be reported together, unless an appropriate modifier is used. For example, a provider should not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

Many procedure codes should not be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same beneficiary encounter.

An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an initial service or a subsequent service. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same beneficiary encounter.

In addition, the descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for one gender should not be reported with HCPCS/CPT codes for theopposite gender.

When is a code the reimbursable code of a PTP code pair?

The Column 1/Column 2 tables are comprised of PTP code pairs. If a provider submits the two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1 code is eligible for payment and the Column 2 code is denied. However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. Supporting documentation must be in the beneficiary's medical record.

To determine when our example code 99215 is the reimbursable code of a PTP code pair, we open the Practitioner PTP Edits Table containing edits from 61000/0213T - R0075/R0070 (or similar range) to search for 99215 in Column 1. We can use the Microsoft Excel filter tool to easily search for all instances of 99215 in Column 1 in the table. (The Filtering the PTP Data Tables section at the end of this booklet provides instructions for using the filter tool in Microsoft Excel.)

Figure 2 shows part of the Practitioner PTP Edits Table containing edits from 61000/0213T - R0075/R0070 (or similar range), with our example code 99215 in Column 1.

1. Column 1 indicates the payable code.
2. Column 2 contains the code that is not payable with this particular Column 1 code, unless a modifier is permitted and submitted.

1. This third column indicates if the edit was in existence prior to 1996.
2. The fourth column indicates the effective date of the edit (year, month, date).
3. The fifth column indicates the deletion date of the edit (year, month, date).
4. The sixth column indicates if use of a modifier is permitted. This number is the modifier indicator for the edit. (The Modifier Indicator Table, shown on page 6 of this booklet, provides further explanation.)
5. The seventh column provides the underlying basis for each PTP edit.

Our search shows a portion of all Column 1/Column 2 PTP code pairs where 99215 is the payable code and every code that is not separately payable when billed with 99215 (unless a modifier is allowed) as a result of the Column 1/Column 2 policies.
Figure 2 shows, for example, that a physician will not be reimbursed for HCPCS code G0102 (Prostate cancer screening; digital rectal examination) together with 99215 (Office or other outpatient visit).

How do you identify all PTP code pairs when a code is not reimbursable or when it is only reimbursable if an appropriate modifier is used?

In other words, you will also wish to know when a code appears as a Column 2 code.
Unlike the Column 1 search, now you must download all of the Practitioner PTP Edits tables and search for Column 2 codes in both. (Similarly, other providers would need to download and search both of the hospital tables.) Use the Microsoft Excel filter tool so all instances of a particular code are displayed together in Column 2. (The Filtering the PTP Data Tables section at the end of this booklet provides instructions for using the filter tool in Microsoft Excel.)
For example, code 99215 appears in Column 2 of both Practitioner PTP Edits tables.
If you perform a Microsoft Excel filter for 99215 in Column 2 of the Practitioner PTP Edits Table containing edits from 0001M/36591 - 25931/G0471 (or similar range), you will see that 99215 is not reimbursed with 01462, Anesthesia for all closed procedures on lower leg, ankle, and foot.
If you perform a filter for 99215 in Column 2 of the Practitioner PTP Edits Table containing edits from 61000/0213T - R0075/R0070 (or similar range), you will see that 99215 is not reimbursed with 99221, Initial hospital care, unless an appropriate modifier is used.

How do you know when an appropriate modifier may be used?

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.
In the modifier indicator column, the indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

Modifier Indicator Table

Modifier Indicator	Definition
0 (Not Allowed)	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

Appendix C: Wound Care Center Superbill

WOUND CARE CENTER DAILY SUPERBILL (CHARGE TICKET)

Date: _____

Physician Initials: _____ Clinician Initials: _____

Diagnosis (Include ICD 10 codes here)

A._____ B._____ C._____ D._____

E._____ F._____ G._____ H._____

Please enter quantity of services performed in "FAC" column for Facility charges, and the quantity of services provided by Physician/NPP in "PRO" column.

	PRO QTY	VISITS – Evaluation & Management	CPT	MOD	FAC CDM #	FAC QTY	PRO QTY	I&D / PARING / BIOPSY	CPT	MOD	FAC CDM #
		New Patient E&M – Level 1	99201					I&D abscess – single or simple	10060		
		New Patient E&M – Level 2	99202					I&D abscess – multiple or complicated	10061		
		New Patient E&M – Level 3	99203					Paring/cutting benign hyperkeratotic lesion (eg: com/callus); 1	11055		
		New Patient E&M – Level 4	99204					Paring/cutting benign hyperkeratotic lesion (eg: com/callus); 2-4	11056		
		New Patient E&M – Level 5	99205					Paring/cutting benign hyperkeratotic lesion (eg: com/callus); >4	11057		
		Estab Pt E&M – Level 1	99211					Biopsy skin – one lesion	11100		
		Estab Pt E&M – Level 2	99212					Biopsy skin – each additional lesion	11101		
		Estab Pt E&M – Level 3	99213			FAC QTY	PRO QTY	STRAPPING/NAILS	CPT	MOD	
		Estab Pt E&M – Level 4	99214					Apply Total Contact Leg Cast	29445	LT/RT	
		Estab PT E&M – Level 5	99215					Apply Unna Boot	29580	LT/RT	
		Hospital OP Clinic Visit (Medicare Only)	G0463					Apply Bilateral Unna Boot	29580	50	
		Postoperative follow-up, included in surgical package	99024					Apply Multilayer comp lower leg	29581	LT/RT	
FAC QTY	PRO QTY	HBO RELATED	CPT	MOD	FAC CDM #			Apply Bilateral Multilayer comp low leg	29581	50	
		HBO_2 Tx – per 30 min	G0277					Trim nondystrophic nails, any #			
		HBO_2 Tx – Physician, NP and PA supervision	99183					Debride nail 1-5	11720		
		$TcPO_2$ / ABI – bilat, 1-2 levels or unilat $\geq$ 3 levels or unilat perform provocative functional maneuvers	93922	MD-26				Debride nail >5	11721		
								Avulsion of nail plate – 1	11730		
		$TcPO_2$ / ABI – bilat, $\geq$3 levels or bilat single level study with provocative functional maneuvers	93923	MD-26				Avulsion of nail plate > 1	11732		
								Excision of nail – partial or complete	11750		
		TcPO2/ABI – unilat. 1-2 levels	93922	52				Chemical Cauterization; granulation tissue	17250		
		Injection – SUBQ or IM	96372			FAC QTY	PRO QTY	SKIN SUBSTITUTES	CPT	MOD	FAC CDM#
		Blood Glucose Check	82962								
		Removal – Impacted Cerumen, requiring instrumentation, unilateral	69210					Apply skin sub – 1st 25 sq cm; Total Wound Surface area up to 100 sq cm (High Bucket)	15271		
FAC QTY	PRO QTY	DEBRIDEMENTS	CPT	MOD	FAC CDM #			Apply skin sub – addl 25 sq cm (no more than "3" units) Total Wound Surface area up to 100 sq cm (High Bucket)	15272		
		Debridement, devitalized tissue first 20 sq cm	97597					Apply skin sub – 1st 100 sq cm; Total Wound Surface area $\geq$ 100 sq cm	15275		
		Debridement, devitalized tissue addl 20 sq cm	97598								
		Debridement, SubQ, first 20 sq cm or less	11042					Apply skin sub-1st 25 sq. cm. Total Wound Surface area up to 100 sq. cm (Low Bucket)	C5271		
		Debridement, SubQ, each addl 20 sq cm or part thereof	11045								
		Debridement, Muscle/Fascia, First 20 sq cm or less	11043					Apply skin sub- add 25 sq. cm. Total Wound Surface area 100 sq. cm. (Low Bucket)	C5272		
		Debridement, Muscle/Fascia, each addl 20 sq cm or part thereof	11046								
		Debridement, Bone, First 20 sq cm or less	11044					Apply skin sub-1st 100 sq. cm. Total Wound Surface area > 100sq. cm. (Low Bucket)	C5273		
		Debridgement, Bone each addl 20 sq cm or part thereof	11047								
		Nonselective Debridement (eg: enzymatic, chemical, mechanical and autolytic)	97602								
FAC QTY	PRO QTY	NPWT	CPT	MOD	FAC CDM #						
		NPWT $\leq$ 50 sq cm	97605								
		NPWT > 50 sq cm	97606								
		NPWT $\leq$ 50 sq cm (disposable)	97607								
		NPWT > 50 sq cm (disposable)	97608								
FAC QTY	PRO QTY										
						FAC QTY	PRO QTY		CPT	MOD	FAC CDM #

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