Questions & Answers

The information provided in this Question & Answer session does not supersede or alter the coverage and documentation policies as outlined in the local coverage determinations (LCD) and Policy articles for the A/B Medicare Administrative Contractors (MAC). Please refer any specific questions you may have to the A/B MAC for your region.


Coverage Criteria

CAHABA GOVERNMENT BENEFIT Administrators doesn’t say excisional debridement is required in the documentation requirements. I have heard that it is required. Can you clarify, please?

We reviewed Cahaba’s Local Coverage Determination (LCD) for Surgery: Debridement Services (L30004). According to the “Documentation Requirements” section, the words, excisional debridement are not required for coverage. Number 3 (Treatment/progress notes) in that section states that the type of tissue or material debrided, as well as the procedures and methods used, are required for coverage. Please contact your Medicare Administrative Contractor (MAC) for specific instructions. Additional information is also located on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDID=30004&ContrId=213&ver=39&ContrVer=1&Date=01%2f01%2f2014&DocID=L30004&bc=iAAAAAgACAAAA%3d%3d&.
IS IT EVER APPROPRIATE TO USE CPT® code 11042 for non-wound services like hyperkeratotic lesions? Providers should always check the LCD in their state or territory to find the requirements for their Medicare Administrative Contractor (MAC). We did note that one contractor, First Coast Service Options, does allow debridement of hyperkeratotic lesions in limited circumstances. The following is stated under “Limitations” in their LCD for Wound Debridement Services (L28774):

- “Paring or cutting of corns or non-plantar calluses. Skin breakdown under a dorsal corn that begins to heal when the corn is removed and shoe pressure is eliminated is not considered an ulcer and does not require debridement unless there is extension into the subcutaneous tissue.”


ISN’T HYPERKERATOTIC TISSUE ALWAYS considered corn/callous care? Yes. Hyperkeratotic tissue is caused by a thickening of the stratum corneum which is the outermost layer of the epidermis. The most common term used is corn or callus. Normally, the removal of these tissues is not covered as it is considered to be part of routine foot care. One contractor, First Coast Service Options, does allow debridement in limited circumstances. For more information, please see their LCD policy, Wound Debridement Services (L28774), located at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. The LCD for your state or territory may be more restrictive.

AT WHAT POINT DO YOU CONSIDER THE tissue removed to be a debridement? Is it 10%, 20%, or 50%? The percent of tissue removed is not a factor in choosing procedure codes for debridement services. The initial CPT® codes from the code range of 11042–11044 (debridement of subcutaneous tissue through debridement of bone) are billed for the first 20 square centimeters or less of tissue removed. CPT® code 97597 (debridement, open wound, devitalized epidermis and/or dermis) describes the first 20 square centimeters or less of epidermis and/or dermis removed. The amount of devitalized tissue removed should be measured and recorded in the patient’s medical record in square centimeters. Additional amounts of tissue removed, greater than 20 square centimeters, would be billed with one unit of CPT® code(s) 11045–11047 (subcutaneous tissue through bone) for each additional 20 square centimeters of tissue removed, or CPT® code 97598 (debridement of epidermis and/or dermis) beyond 20
square centimeters. For LCDs related to podiatry debridement of ulcers and wounds, please refer to the CBR201408 Recommended Links webpage located at http://www.cbrinfo.net/cbr201408-recommended-links.html.

**ARE FIVE SURGICAL DEBRIDEMENT procedures allowed per year, per wound or just per person?** MACs are now reviewing claims after the fifth surgical debridement for CPT® codes 11043 and/or 11044 per beneficiary, per year. These claims are only payable upon appeal according to the LCD. Providers should check with their MAC for questions/concerns regarding the number of surgical debridement procedures allowed per year. A listing of MACs by state is located at http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-Feb-2014.pdf.

**DID NOT HEAR ANYTHING DURING the webinar about supervising physicians or date last seen requirements for CPT® codes 11720–11721?** CBR201408 Podiatry: Debridement of Ulcers and Wounds did not include CPT® code 11720 (debridement of nail(s) by any method(s); 1 to 5), or CPT® code 11721 (debridement of nail(s) by any method(s); 6 or more). Therefore, we cannot provide information regarding supervising physicians or date last seen requirements. At the time this question was posted, there were 14 LCDs covering CPT® code 11720. Providers can find information on debridement of nails in the Medicare Coverage Database located at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

**WHAT SHOULD PROVIDERS DO IF A patient has a wound in January and then again in November of the same year?** The patient’s medical record documentation may be required to support two or more different wounds being treated at different times. Anatomic modifiers LT (left) and RT (right) could be appended to the codes in order to clarify the wound site, when applicable. Providers should always check with their MACs to ensure their claims are coded and submitted correctly. A listing of MACs can be found at http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-Feb-2014.pdf.

**IS THERE A GLOBAL PERIOD FOR THE debridement codes covered in this webinar?** All of the CPT® codes (97597–97598 and 11042–11047) in CBR201408, have been assigned “000” global days, meaning there is no pre-operative period, no post-operative days and the visit on the day of the procedure is generally not payable. More information is available in...
DOCUMENTATION

WHEN DOCUMENTING THE ACTUAL size of devitalized tissue removed, is it ok to document a percentage of the wound debrided vs. pre-debridement measurement and post-debridement measurement? According to CPT® 2013 Professional Edition, the size of the devitalized tissue removed should be documented in square centimeters by measuring the length in centimeters by the width in centimeters. The percentage of tissue removed compared to the total size of the wound should not be considered. The CPT® 2013 Professional Edition provides thorough information and is available for purchase at http://www.amazon.com/2013-Standard-Current-Procedural-Terminology/dp/1603596836/ref=sr_1_6?s=books&ie=UTF8&qid=1412807444&sr=1-6.

CPT® Codes

THIS IS THE FIRST TIME WE HAVE heard that CPT® code 97602 (removal of devitalized tissue, non-selective debridement) is bundled. Please elaborate on what is bundled with CPT® code 97602? CPT® code 97602 is bundled under Medicare Part B. When this service is provided by a discipline that receives reimbursement based on the Medicare Physician Fee Schedule (MPFS), this code is not separately reportable or payable. It is bundled with a modifier indicator of "0" into CPT® codes 97597, 97598, 97605 (negative pressure wound therapy less than or equal to 50 square centimeters), and CPT® code 97606 (negative pressure wound therapy greater than 50 square centimeters). According to the National Correct Coding Initiative (NCCI) tables, CPT® code 97602 is bundled into many services in the neuroplasty section of the manual with a modifier indicator of "1." Providers should contact their MACs if they have specific questions pertaining to coding their claims. For additional information, please see the NCCI tables, manual and the booklet, “How to Use the Medicare National Correct Coding Initiative (NCCI) Tools,” located at http://www.cms.gov/NationalCorrectCodInitEd.
CAN WE USE CPT® CODES 17250 and 97597 FOR THE SAME WOUND ON THE SAME DATE OF SERVICE (DOS)? CPT® codes 97597/97598 (active wound care management) are bundled into CPT® code 17250 (chemical cauterization of granulation tissue) with a modifier indicator of “1” according to the National Correct Coding Initiative (NCCI) Physician Edits. The only time both codes are billed together is when the services take place at a different anatomic site or different session, or the services are for a different diagnosis. For more information, please see the NCCI edits, located at http://www.cms.gov/NationalCorrectCodInitEd.

MODIFIERS 58 AND 59

IF A PROVIDER FINDS IT NECESSARY TO DO SIGNIFICANTLY MORE DEBRIDEMENT OF A SURGICAL WOUND DURING THE GLOBAL PERIOD, IS IT APPROPRIATE TO APPEND THE 58 MODIFIER IF THE DOCUMENTATION SUPPORTS IT? Modifier 58 describes a staged or related procedure or service by the same physician or other qualified health care professional during the post-operative period. If the initial procedure performed has a global period of 10 or 90 days and the subsequent procedure took place during that period of time, and it was planned or anticipated at the time of the original procedure, then Modifier 58 can be used. In these instances, typical follow-up care, such as removal of sutures and dressing changes, is included in the global surgical package and cannot be billed separately. Modifier 58 should not be used for subsequent procedures performed in the office setting if the subsequent procedure is not part of the treatment plan. Also, modifier 58 should not be reported if the subsequent procedure is unrelated to the original surgery. Additional information on modifier 58 can be found in the Global Surgery Fact Sheet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf.

WHEN DOES THE MODIFIER 59 CHANGE GO INTO EFFECT? According to the Centers for Medicare & Medicaid Services (CMS), the new modifiers to supplement modifier 59 will become effective on January 1, 2015. Per the CMS publication, Specific Modifiers for Distinct Procedural Services, MLN Matters® Number: MM8863 [see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf], CMS is establishing four new Healthcare Common Procedure coding System (HCPCS) modifiers to define subsets of modifier 59 for “Distinct Procedural Service.” The four new modifiers are:
• **XE**: Separate Encounter, a service that is distinct because it occurred during a separate encounter

• **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

Per the MLN Matters® article, CMS will initially accept either modifier 59 or a more selective modifier from the new set as correct coding. However, the article states that the “the rapid migration of providers to the more selective modifiers is encouraged.” For more information, please see MLN Matters® Number: MM8863 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf). Additional clarification is also available in the Modifier 59 Article located at [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf).

**DOES MODIFIER 58 NEED TO BE A planned procedure?** Yes. Modifier 58 is used when a staged or related surgical procedure is performed by the same physician during the post-operative period of another procedure. When debridement procedures are repeated, subsequent services do not require modifier 58. In order to report modifier 58, the subsequent procedure must be:

• Planned or anticipated at the time of the initial procedure

• More extensive than the original surgery

• For therapy following a surgical procedure


**CAN WE BILL MODIFIER 58 FOR AN unplanned, but related procedure?** No. When an unplanned complication of the original surgery occurs that requires a return to the operating room (OR), modifier 78 should be used. Treatment of a complication from the original surgery that does not require a return to the operating room is not separately payable. Medicare considers treatment for complications that do not require a return
to the OR as part of the global surgical package. For example, an office visit to perform a dressing change for a minor infection is not separately reportable. For clarification, please see the Medicare Claims Processing Manual, Chapter 12, Section 40—Surgeons and Global Surgery located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

**METHODS & RESULTS**

**WHAT PERCENTAGE BREAKPOINT IS considered Significantly Higher for the provider?** For all three analyses, a chi-square test was used to compare the provider to his/her peer group. Also, an alpha value of 0.05 was chosen as the threshold for significance. The provider’s percentage and number of observations determine if the provider crosses this threshold or not. If the provider is found to be *Significantly Higher*, then it is statistically unlikely that his/her percentage occurred by random chance. The “CBR201408 Statistical Debriefing” describes the tables and figures used and is available at [http://www.cbrinfo.net/cbr201408-statistical-debriefing.html](http://www.cbrinfo.net/cbr201408-statistical-debriefing.html).

**IF A PROVIDER’S RESULTS ARE NOT significantly different than his/her peers, will he/she still get a CBR?** In order for a provider to receive a CBR, he/she must meet certain thresholds. One of these thresholds is a significant result in at least one analysis. More information about this topic is in the “CBR201408 Statistical Debriefing” report located at [http://www.cbrinfo.net/cbr201408-statistical-debriefing.html](http://www.cbrinfo.net/cbr201408-statistical-debriefing.html).

**WERE THE 5000 PEOPLE THESE REPORTS sent to picked randomly?** No. The providers were chosen first by the number of significant comparisons, and second by the total allowed charges. These providers were identified as having different billing patterns when compared to their peers.
**SELF-AUDITS**

**SHOULD PROVIDERS PERFORM SELF-AUDITS for the year 2013 only or cover previous years as well?** Comparative Billing Reports (CBRs) are for educational purposes and allow providers to compare their billing patterns to those of their peers in the state and across the nation. A CBR is not a precursor to an audit. However, because Recovery Auditors are independent in choosing their review topics and have a three year look-back period, it may be beneficial to review records for years prior to 2013 if a review of more current records supports incorrect billing or a deficiency in documentation. Please visit our “Self-Audit Help” webpage at http://www.cbrinfo.net/self-audit-help.html for more information regarding self-audits.

**MISCELLANEOUS**

**DOES THE RECEIPT OF A CBR INDICATE a better chance of a Medicare audit?** At the time the webinar was presented on October 29, 2014 and October 30, 2014, neither eGT nor its partner, Palmetto GBA, was aware of any audits regarding debridement services planned by the Centers for Medicare & Medicaid Services (CMS). If interested in information on self-audits, please see the “Self-Audit Help” webpage located at http://www.cbrinfo.net/self-audit-help.html.

**WILL THE WEBINAR SLIDES BE AVAILABLE later to print and reference?** A recording of the entire webinar, including slides, is available in an MP4 format at http://www.cbrinfo.net/assets/cbr201408-webinar-recording.mp4.

**WILL THE WEBINAR PRESENTATION BE available without the recording attached?** No. At the present time, the webinar is not available without the recording attached.