

*Note: These FAQ's reflect standard coding guidance and practice. It is important to keep in mind that payment policies vary from payer to payer.*

## **Active Wound Care Management**

### **1. What is active wound care management?**

Active wound care management includes debridement of necrotic/devitalized or infected tissue and biofilm, stimulation of new tissue growth, control of infection and pain, and nutritional support. Proper management of wounds involves modifying pressure distribution or off-loading pressure; regular repositioning; establishing and supporting adequate circulation; management of edema; management of comorbidities; infection and pain control; nutritional support; wound bed preparation including irrigation and debridement and appropriate advanced wound dressings. The primary goals of active wound care procedures are to restore integumentary integrity and prevent future tissue breakdown.

A variety of techniques are used to debride/cleanse wounds and promote healing in active wound care management.

### **2. What is the role of the physical therapist in active wound care management?**

Physical therapists examine skin integrity to assess the effects of a wide variety of disorders that result in skin and subcutaneous changes, including pressure, vascular (e.g. venous, arterial), and neuropathic (e.g., diabetic) ulcers; burns and other traumas; and a number of diseases (e.g., soft tissue disorders).<sup>1</sup> They examine wounds for tissue type, drainage, color, temperature, odor, texture, condition of surrounding tissues, size and to determine if tunneling, tracts and/or undermining are present. The physical therapist evaluates the findings and develops a prognosis and plan of care that may include selective or non-selective debridement without the use of anesthesia, followed by irrigation and the selection of appropriate advanced wound care dressings and interventions. The physical therapist instructs the patient and/or caregiver in caring for the wound.

### **3. What is selective debridement?**

Selective debridement is the removal of devitalized tissue from a wound using techniques in which the provider has control over which tissue is removed and which is left behind. Selective techniques include pulsed lavage with suction (PLWS) at 4-15 psi, low frequency, contact ultrasound<sup>2</sup>, and sharp debridement (using scissors, a scalpel and/or forceps).<sup>3</sup>

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<sup>1</sup> *Guide to Physical Therapist Practice*. Second ed. Alexandria, VA: American Physical Therapy Association; 2003:66.

<sup>2</sup> Kloth LC, Niezgoda JA. Ultrasound for wound debridement and healing. In: McCulloch JM, Kloth LC. *Wound Healing: Evidence-Based Management*. 4<sup>th</sup> ed. Philadelphia, PA: F.A.Davis Company; 2010.

<sup>3</sup> *CPT® 2005 changes: an insiders' view*. Chicago, IL: American Medical Association; 2004: 194-197.

#### **4. What is sharp debridement?**

Sharp debridement is a non-surgical technique that includes use of a scalpel, scissors, and/or other sharp instruments to remove non-viable tissue.<sup>4</sup> Surgical debridement is the removal of nonviable and viable tissue, and is not in the scope of practice of physical therapists.

#### **5. What is autolytic debridement?**

Autolytic debridement uses occlusive or semi-occlusive dressings to keep wound fluid in contact with necrotic tissue, resulting in a softening/liquefaction and sloughing of necrotic tissue, including eschar. Dressings used for autolysis include foam, calcium alginate, hydrocolloids, hydrogels and transparent films. Autolytic debridement may be performed alone, or in conjunction with other wound debridement techniques such as sharp or enzymatic debridement.<sup>5</sup>

#### **6. What is nonselective debridement?**

Non-selective debridement is the removal of devitalized tissue from a wound using wet-to-dry dressings (rarely used), enzymatic application, abrasion or autolysis.

#### **7. What is negative pressure wound therapy?**

Negative pressure wound therapy (NPWT) is the use of a vacuum-assisted drainage collection to accelerate and promote healing of wounds, including neuropathic and pressure ulcers. The application of suction results in removal of tissue exudates which reduces bio-burden in the wound bed. The vacuum pressure also stimulates the wound bed, reduces localized edema and improves local oxygen supply.<sup>6</sup> Mechanical stress on the tissue also helps to increase the rate of cellular proliferation, granular tissue formation and new vessel growth.

#### **8. What is low frequency non-contact ultrasound?**

Low frequency, non-contact, non-thermal ultrasound is delivered through normal saline to the wound area to promote tissue healing. Therapy outcomes include active cell stimulation, decreased bacteria and bioburden, increased blood flow and gentle cleansing.<sup>7,8</sup>

#### **9. How is electrical stimulation used in active wound care management?**

Electrical stimulation involves the direct application of an electric current to the area of a non-healing wound to stimulate healing. The presence of a wound is believed to disrupt the electrical field in the skin which disrupts the healing process.

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<sup>4</sup> Bates-Jensen B, Apeles NC. Management of Necrotic Tissue. In: Sussman C, Bates-Jensen B, eds. *Wound Care: A Collaborative Practice Manual for Health Professionals*. 3<sup>rd</sup> ed. Baltimore, MD: Lippincott, Williams & Wilkins; 2007: 197-214.

<sup>5</sup> Bates-Jensen B, Apeles NC. Management of Necrotic Tissue. In: Sussman C, Bates-Jensen B, eds. *Wound Care: A Collaborative Practice Manual for Health Professionals*. 3<sup>rd</sup> ed. Baltimore, MD: Lippincott, Williams & Wilkins; 2007: 197-214.

<sup>6</sup> Gabriel A, Hiltabidel E, Valenzuela A, Gupta S. Management of the Wound Environment with Negative Pressure Wound Therapy. In: Sussman C, Bates-Jensen B, eds. *Wound Care: A Collaborative Practice Manual for Health Professionals*. 3<sup>rd</sup> ed. Baltimore, MD: Lippincott, Williams & Wilkins; 2007: 683-697.

<sup>7</sup> MIST Therapy System; Celleration; [http://www.celleration.com/mist\\_therapy\\_system.html](http://www.celleration.com/mist_therapy_system.html); "Indications for Use"; accessed March 22, 2010.

<sup>8</sup> Kloth LC, Niezgodna JA. Ultrasound for wound debridement and healing. In: McCulloch JM, Kloth LC. *Wound Healing: Evidence-Based Management*. 4<sup>th</sup> ed. Philadelphia, PA: F.A.Davis Company; 2010.

## 10. What procedure codes are reported for active wound care management?

*Selective Debridement: The codes established to report selective debridement are based on total surface area of the wound(s)*

Code	Description	Note
97597	Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudates, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session; total wound(s) surface area; first 20 square centimeters or less.	Do not report with surgical debridement codes 11042-11047 for the same wound.  Includes instruction(s) for ongoing care, application and removal of dressings and use of whirlpool. Do not separately report these procedures.  The code description was revised effective January 1, 2011. <sup>9,10</sup>
97598	Same as 97597; each additional 20 square centimeters, or part thereof (list separately in addition to code for primary procedure).  Effective January 1, 2011 this is an add-on code.	Same as above.  Prior to January 1, 2011, this code described total wound(s) surface area greater than 20 square centimeters.

### *Non-selective Debridement*

Code	Description	Note
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	The application and removal of dressings associated with debridement techniques is considered part of the work associated with the procedures and should not be reported separately.  <i>Bundled under the Medicare Physicians Fee Schedule.</i>

<sup>9</sup> CPT® 2005 changes: an insider's view. Chicago, IL: American Medical Association; 2004: 194-197.

<sup>10</sup> CPT® 2011 changes: an insider's view. Chicago, IL: American Medical Association; 2010: 228-229.

*Negative Pressure Wound therapy (NPWT): The codes established to report negative pressure wound therapy are based on total surface area of the wound(s)*

<b>Code</b>	<b>Description</b>	<b>Note</b>
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Coverage under private insurance may be subject to terms, conditions and limitations of the benefit plan, particularly for DME.
97606	Same as 97605; total wound(s) surface area greater than 50 square centimeters	Same as above.

*Other codes reported for wound care*

G0281	Electrical stimulation, (unattended), to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	See question 12 below
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	Not covered by Medicare
G0329	Electromagnetic therapy to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers	See question 12 below
97014	Application of a modality to one or more areas; electrical stimulation (unattended)	This code should be reported when a payer does not require use of code G0281
29581	Application of multi-layer venous wound compression system, below knee  <i>(The descriptor for this code is currently being reviewed for possible expansion to areas other than below knee)</i>	Should not be reported in conjunction with 29540, 29580, 29581
0183T	Low frequency non-contact non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Coverage varies by payer – check payer policies

### **11. Can physical therapists report debridement services using the 1104x series debridement codes?**

While most of the CPT codes used by physical therapists are in the 97000 series, a provider can report any code as long as the provider is qualified to perform the service represented by the specific code<sup>11</sup> (e.g., within the provider's scope of practice).

<sup>11</sup> American Medical Association. A Comparative Look at the Physical Medicine and Rehabilitation Codes. *CPT Assistant*. 1998;December:1

Typically, physical therapists will report active wound care management using codes in the 97xxx (physical medicine) series.<sup>12</sup> The 110xx series describes surgical excision that typically requires anesthesia.

Effective January 1, 2011 the 1104x series of codes underwent significant revision, including the deletion of two codes (11040, 11041) and the addition of three add-on codes (11045, 11046 and 11047). Complete code descriptions are available in the Current Procedural Terminology manual (2011 or later).

### **12. Do insurers cover all active wound care management techniques?**

No. Check payer policy to determine coverage. Medicare has a non-coverage policy for use of infrared and/or near infrared light and/or heat, including monochromatic infrared energy for the treatment of diabetic and/or non-diabetic peripheral neuropathy, skin wounds and ulcers, or subcutaneous tissues. Medicare's technology assessment concluded that there is insufficient evidence to support the use of infrared devices for diabetic and non-diabetic peripheral neuropathy, wounds and/or ulcers, and subcutaneous tissues.

Medicare issued a National Coverage Determination regarding the use of electrical stimulation for chronic wound management. The determination notes that Medicare will cover electrical stimulation for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. Electrical stimulation must be used in addition to standard wound care treatment and will be covered only after standard wound therapy has been provided for at least 30 days and there are no measurable signs of improved healing. Medicare requires the use of G0281 to report electrical stimulation and G0329 for electromagnetic therapy for the treatment of wounds.

### **13. Can I bill for the dressings used in active wound care management?**

If a payer is using the Resource-Based Relative Value Scale (RBRVS) methodology for payment, supplies are included in the practice expense component of the procedure code values and are not separately payable.

However, in cases where a payer is using another payment methodology (such as usual, customary, and reasonable), then separate payment for supplies may be allowed. Contact payers to clarify their billing requirements and methodology.

### **14. Can I bill for a dressing change?**

The application and removal of dressing associated with debridement is considered part of the work associated with the procedures. Therefore, application and removal of dressings would not be reported separately. If a dressing change occurs without any active wound care management, then it would not be appropriate to report any of the wound care management codes to describe the service.

### **15. What should be included in documentation of active wound care management?**

Documentation should demonstrate the skilled nature of services provided in addition to what services were provided (including frequency, intensity, time, duration and level of physical and/or cognitive assistance provided, as appropriate).

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<sup>12</sup> American Medical Association. Coding Consultation: Active Wound Care Management, 97597, 97606, 11040, 11044 (Q&A). *CPT Assistant*. 2005; June: 10.

Documentation of each visit/encounter shall include the following elements:

<b>Element</b>	<b>Example</b>
Patient/client self-report (as appropriate).	Patient reports decreased wound odor since last treatment.
Identification of specific interventions provided, including frequency, intensity and duration and level of physical and/or cognitive assistance provided as appropriate.	Stage IV sacral pressure ulcer treated with PLWS (pulsed lavage with suction), 2000 ml NS at 6-15 PSI, at 100 mmHg suction, with small splash shield and flexible tip, including tracts and undermining. Sharp debridement of necrotic tissue, including eschar and slough was performed with forceps and scissors. Applied barrier film periwound, calcium alginate to loosely fill wound, covered and secured with foam dressing. Patient was able to turn to right side with minimal assist for procedure. CNA present during treatment to assist in maintaining position.
Changes in patient/client impairment, activity limitation, and participation restrictions as they relate to the plan of care.	Patient remaining off sacral area, with resultant control of pressure. Continues with protein calorie malnutrition with prealbumin at 10.2, but improving. Dietitian involved.
Response to interventions, including adverse reactions, if any.	Note decreased necrotic tissue now at ~40% (from 60% last visit). ~5% bone visible, ~55% granulation tissue. Moderate serosanguineous drainage, no longer purulent. No odor post PLWS. No periwound erythema, induration or edema.
Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.	Quantity of necrotic tissue dictates continued PLWS treatment and sharp debridement at same frequency. Decreased purulent drainage and patient adherence to pressure redistribution positioning does not indicate need for increased frequency.
Communication/consultation with providers/patient/client/family/significant other.	Reviewed importance of no supine positioning and protein intake with patient and daughter, both expressed understanding.

## Element

Documentation to plan for ongoing provision of services for the next visit(s), which is suggested to include, but not be limited to: the interventions with objectives, progression parameters, and precautions, if indicated.

## Example

With amount of necrotic tissue remaining, treatment will continue every Monday, Wednesday and Friday until eschar no longer present and necrotic tissue  $\leq 20\%$ , at which time treatment will decrease to Mondays and Thursdays absent any other significant changes. PLWS and PT can be discontinued when wound is free of necrotic tissue, and tracts and undermining are manageable with non-powered irrigation, at which time nursing may assume care of the wound.

Additional documentation resources are available on the APTA website at [www.apta.org/documentation](http://www.apta.org/documentation).

### **16. Where can I review research regarding the effectiveness of various wound care techniques?**

APTA members can review evidence in the APTA Hooked on Evidence database and in Open Door: APTA's Portal to Evidence-based Practice. Non-members can subscribe to APTA Hooked on Evidence.

The Hooked on Evidence database is at <http://www.hookedonevidence.org/index.cfm>.

Open Door is at: <http://www.apta.org/OpenDoor>.

*Tip: Suggested key words for searches include debridement, PLWS, NPWT, compression, low frequency ultrasound.*

### **17. Where can I get more information or assistance?**

American Physical Therapy Association  
Payment Policy and Advocacy department  
1111 North Fairfax Street  
Alexandria, VA 22314  
800/999-2782 x8531  
703/706-8567 (fax)  
[Advocacy@apta.org](mailto:Advocacy@apta.org)

American Physical Therapy Association  
Section on Clinical Electrophysiology and Wound Management  
Wound Management Special Interest Group  
Executive Director: Anne Daugherty  
800/999-2782 x8512  
[annedaugherty@apta.org](mailto:annedaugherty@apta.org)  
[www.aptasce-wm.org](http://www.aptasce-wm.org)

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