Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-093 **Date: JUNE 27, 2003**

CHANGE REQUEST 2733

SUBJECT: Correction: Coverage and Billing Requirements for Electrical Stimulation for the Treatment of Wounds

This Program Memorandum (PM) is correcting Transmittal AB-02-161 issued November 8, 2002. The correction only includes adding bill type of 85X for Critical Access Hospitals.

This PM summarizes coverage and provides billing requirements for electrical stimulation for the treatment of wounds. Refer to § 35-102 of the Coverage Issues Manual (CIM) for complete information regarding the coverage policy.

Coverage

For services performed on or after April 1, 2003, Medicare will cover electrical stimulation for the treatment of wounds only for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. All other uses of electrical stimulation for the treatment of wounds are not covered by Medicare. Electrical stimulation will not be covered as an initial treatment modality.

The use of electrical stimulation will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician, but no less than every 30 days by a physician. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100% epithelialzed wound bed.

Intermediary Billing Instructions

Billing should be completed on the Form CMS-1450 (UB-92) or electronic equivalent.

The following bill types (settings) for this newly covered service are as follows:

12X - Hospital Inpatient Part B
13X - Hospital Outpatient
22X - Skilled Nursing Facility (SNF) (hospital- based Inpatient Part B)
Note: 22x is used for free standing SNFs as well as hospital based. There is no differentiation in TOB for this aspect.
23X - Skilled Nursing Facility (Outpatient)
71X – Rural Health Clinics (RHC)
73X – Federally Qualified Health Clinics (FQHC)
74X - Outpatient Rehabilitation Facility (ORF)
75X – Comprehensive Outpatient Rehabilitation Facility (CORF)
85X – Critical Access Hospitals (CAH)

Applicable HCPCS Codes:

- **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.

Short descriptor: Elec stim unattend for press

- **G0282*-** Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 **(Not covered by Medicare)**

Short descriptor: Elect stim wound care not paid

- **G0295 -** Electromagnetic stimulation, to one or more areas **(Not covered by Medicare)**

Short descriptor: electromagnetic therapy one

97014 -- electrical stimulation unattended **(NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes as described in G0281 and G0282.)**

97032 -- Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes. **(NOTE: 97032 should NOT be reported for wound care of any sort because electrical stimulation for wound care does not require constant attendance.**)

***(These G codes are going to be on the Therapy Abstract file for 2003.)**

Payment Requirements

Medicare will not cover the device (Code E0761) used for the electrical stimulation for the treatment of wounds. However, Medicare will cover the service. Payment for these services is made under the Medicare Physician Fee Schedule for hospitals, CORFs, ORFs, OPT, and SNFs.

Payment methodology for both independent and provider-based RHCs and free-standing & provider based FQHCs is made under the all- inclusive rate for the visit furnished to the RHC/FQHC patient to obtain the therapy service. Only 1 payment will be made for the visit furnished to the RHC/FQHC patient to obtain the therapy service.

Payment methodology for CAH is payment must be made on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services, in which case, procedures outlined in §3610.00 of the Medicare Intermediary Manual should be followed.

Part B deductible and coinsurance apply**.**

Applicable Revenue Codes

The following revenue codes must be used in conjunction with the HCPCS codes identified:

420 – Physical Therapy
430 – Occupational Therapy
520, 521 – (RHC)
977, 978 – (CAH) - Method II CAH professional services only

Carrier Billing Instructions

Applicable HCPCS Codes

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Short descriptor: Elec stim unattend for press

- **G0282 -** Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 **(Not covered by Medicare)**

Short descriptor: Elect stim wound care not pd

- **G0295 -** Electromagnetic stimulation, to one or more areas **(Not covered)**

Short descriptor: electromagnetic therapy one

97014 -- electrical stimulation unattended. **(NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes as described in G0281 and G0282.)**

97032 -- Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes. **(NOTE: 97032 should NOT be reported for wound care of any sort because electrical stimulation for wound care does not require constant attendance.**)

Carrier Claims Requirements

Follow the general instruction for preparing claims in §2010, Purpose of Health Insurance Claim Form CMS-1500, Medicare Carriers Manual (MCM) Part 4, Chapter 2. Claims for electrical stimulation for the treatment of wounds should be submitted on health insurance claim Form CMS-1500 or electronic equivalent. Claims should be processed in accordance with §4020, Review of Health Insurance Claim Form CMS-1500, of Part 3, Chapter IV of the MCM.

Carrier Payment Requirements

Payment and pricing information is on the April update of the Medicare Physician Fee Schedule Database (MPFSDB). Pay for this service on the basis of the MPFS. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge (refer to MCM Part 3, chapter VII, §7555 for more information).

Provider Notification

Contractors should notify providers of this new national coverage on their Web site within 2 weeks of receiving this instruction, in regularly published bulletins and in routinely scheduled training sessions. In addition, if you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about " Coverage and Billing Requirements for Electrical Stimulation for the Treatment of Wounds" is available on your Web site.

The *effective date* for this PM is April 1, 2003.

The *implementation date* for this PM is July 11, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.