Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-161 **Date: NOVEMBER 8, 2002**

CHANGE REQUEST 2313

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

This Program Memorandum (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 is on the 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)

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

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 **(Not covered by Medicare)**

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 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 E 0761) 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 SNF.

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 one payment will be made for the visit furnished to the RHC/FQHC patient to obtain the therapy service.

Payment methodology for critical access hospitals (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 Part A 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)

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

  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 **(Not covered by Medicare)**

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 wound care does not require constant attendance)**

Carrier Payment Requirements

Payment and pricing information will be 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).

Claims Requirements

Follow the general instructions for preparing claims as indicated in the electronic claims specifications contained at www.cms.hhs/gov/providers/edi/default.asp, as discussed in Medicare Carriers' Manual (MCM) Part 3 §3023.6A or the addenda to Medicare Intermediary Manual (MIM), Part 3 §3600, and as reported in the Health Insurance Portability and Accountability Act electronic transactions PM issued by CMS. Instructions for the limited number of claims submitted on paper are located in MCM Part 4 §2010 or MIM Part 3 §3604.

Provider Notification

Contractors should notify providers of this new national coverage on their Web site, in regularly published bulletins and in routinely scheduled training sessions.

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

The *implementation date* for this PM is April 1, 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.