CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 124 **Date: MARCH 19, 2004**

CHANGE REQUEST 3149

I. SUMMARY OF CHANGES: This instruction provides policy and claims processing instructions for Electrical Stimulation and Electromagnetic Therapy.

This instruction:

(1) Adds new HCPCS G0329 to the list of codes approved for payment by Medicare;

(2) Specifies by provider type which HCPCS codes can be billed to the FIs; and

(3) Adds Electrical Stimulation and Electromagnetic Therapy information to the new Internet Only Manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	32/Table of Contents
R	32/10/Wound Treatments
R	32/10.1/Electrical Stimulation
N	32/10.2/Electromagnetic Therapy

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 124	Date: March 19, 2004	Change Request 3149

SUBJECT: Billing and Coding Requirements for Electromagnetic therapy for the Treatment of Wounds

I. GENERAL INFORMATION

This instruction summarizes coverage and provides billing requirements for electromagnetic therapy for the treatment of wounds. Please refer to Publication 100-03 (National Coverage Determinations Manual), Section 270.1 for complete coverage policy.

A. Background: For services performed on or after July 1, 2004, Medicare will cover electromagnetic therapy for the treatment of wounds only for chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous statis ulcers. All other uses for electromagnetic therapy for the treatment of wounds will not be covered.

The use of electromagnetic therapy for the treatment of wounds 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 electromagnetic therapy is being used to treat wounds, wounds must be evaluated periodically by the treatment physician, but no less than every 30 days by a physician. Continued therapy with electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electromagnetic therapy must be discontinued when the wound demonstrates a 100% epithelialzed wound bed. Unsupervised home use of these treatments will not be covered as that has not been found to be reasonable and necessary.

B. Policy: Refer to the Medicare National Coverage Determinations Manual, Section 270.1

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their website of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3149.1	The Medicare contractor and CWF shall apply the following Healthcare Procedural Coding System (HCPCS) Codes and Type of Service (TOS) for electrical magnetic therapy. **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 not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care. Short descriptor: electromagnetic therapy for wounds TOS = 1, U,W	SSM (FI, Local Part B Carrier) And CWF
3149.2	The FI shall accept electromagnetic therapy services when billed on the following types of bills: 12x, 13x, 22x, 23x, 71x, 73x, 74x, 75x and 85x.	SSM (FI)
3149.3	The FI shall apply the following revenue codes in conjunction with the HCPCS codes identified: 420 – Physical Therapy; 430 Occupational Therapy; 520, 521 – (RHC) and 977,978 (CAH) *(Method II CAH professional services only).*	SSM (FI)
3149.4	The FI shall pay for electromagnetic therapy under the Medicare Physician Fee Schedule for hospitals, Comprehensive Outpatient Rehabilitation Centers (CORFs), Outpatient Rehabilitation Centers (ORFs), Outpatient Physical Therapy (OPT) and Skilled Nursing Facilities (SNFs).	SSM (FI)
3149.5	The FI shall pay for Critical Access Hospitals (CAHs) on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services.	SSM (FI)
3149.6	The FI shall pay for both independent and provider-based (Rural Health Clinics) RHCs and free-standing & provider based Federally Qualified Health Centers (FQHCs)under the all-inclusive rate for the visit furnished to the RHC/FQHC) patient to obtain the therapy service.	SSM (FI)
3149.6.1	The FI shall make only one payment for the visit furnished to the RHC/FQHC patient to obtain the therapy service.	SSM (FI)
3149.7	The Medicare contractor shall apply coinsurance and deductible to payments for electromagnetic therapy except for payments by the FI to FQHCs where only co-insurance applies.	SSM (FI & Local Part B Carrier)

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date:** July 6, 2004 **Pre-Implementation Contact(s):** Yvette Cousar 410-786-2160 (Carrier claims processing); Patricia Barrett 410-786-0508 (FI claims processing), Lorrie Ballantine 410-786-7543 & Pat Brocato-Simons 410-786-0261 (coverage policy) **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 124, 03-19-04)

10 - Wound Treatments

(Rev 124, 03-19-04)

10.1 - Electrical Stimulation

(Rev 124, 03-19-04)

A - Coding Applicable to Carriers & Fiscal Intermediaries (FIs)

Effective April 1, 2003, a National Coverage Decision was made to allow for Medicare coverage of Electrical Stimulation for the treatment of certain types of wounds. The type of wounds covered are 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.

Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Section 270.1 (www.cms.hhs.gov/masnuals/103 cov determ/ncd103index.asp)

The applicable Healthcare Common Procedure Coding System (HCPCS) code for Electrical Stimulation and the covered effective date is as follows:

HCPCS	*Definition*	*Effective Date*
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*	*04/01/2003*

Medicare will not cover the device used for the electrical stimulation for the treatment of wounds. However, Medicare will cover the service. Unsupervised home use of electrical stimulation will not be covered.

B - FI Billing Instructions

The applicable types of bills acceptable when billing for electrical stimulation services are 12X, 13X, 22X, 23X, 71X, 73X, 74X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs.

FIs pay for electrical stimulation services under the Medicare Physician Fee Schedule for hospitals, Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), Outpatient Physical Therapy (OPT) and Skilled Nursing Facility (SNF).

Payment methodology for independent Rural Health Clinic (RHC), provider-based RHCs, free-standing Federally Qualified Health Center (FQHC) and 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 Critical Access Hospital (CAH) is payment is made on a reasonable cost basis unless the CAH has elected the Optional Method and pay 115% of the MPFS amount for the HCPCS code.

In addition, the following revenues code must be used in conjunction with the HCPCS code identified:

Revenue Code	*Description*
420	*Physical Therapy*
430	*Occupational Therapy*
520	*Federal Qualified Health Center*
521	*Rural Health Center*
977, 978	*Critical Access Hospital- method II CAH professional services only*

C - Carrier Claims

Carriers pay for Electrical Stimulation services billed with HCPCS codes G0281 based on the MPFS. Claims for Electrical Stimulation services must be billed on the CMS 1500 or the electronic equivalent following instructions in Chapter 12 of this manual (www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

D - Coinsurance and Deductible

The Medicare contractor shall apply coinsurance and deductible to payments for ABPM services except for services billed to the FI by FQHCs. For FQHCs, only co-insurance applies.

10.2 - Electromagnetic Therapy

A - HCPCS Coding Applicable to Carriers & Fiscal Intermediaries (FIs)

Effective July 1, 2004, a National Coverage Decision was made to allow for Medicare coverage of electromagnetic therapy for the treatment of certain types of wounds. The type of wounds covered are chronic Stage III or Stage IV pressure ulcers, arterial

ulcers, diabetic ulcers and venous stasis ulcers. All other uses of electromagnetic therapy for the treatment of wounds are not covered by Medicare. Electromagnetic therapy will not be covered as an initial treatment modality.

The use of electromagnetic therapy 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 electromagnetic therapy 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 electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electromagnetic therapy must be discontinued when the wound demonstrates a 100% epithelialzed wound bed.

Coverage policy can be found in Medicare National Coverage Determinations Manual, Chapter 1, Section 270.1. (www.cms.hhs.gov/masnuals/103 cov determ/ncd103index.asp)

The applicable Healthcare Common Procedure Coding System (HCPCS) code for Electrical Stimulation and the covered effective date is as follows:

HCPCS	*Definition*	*Effective Date*
G0329	*ElectromagneticTherapy, 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*	*07/01/2004*

Medicare will not cover the device used for the electromagnetic therapy for the treatment of wounds. However, Medicare will cover the service. Unsupervised home use of electromagnetic therapy will not be covered.

B - FI Billing Instructions

The applicable types of bills acceptable when billing for electromagnetic therapy services are 12X, 13X, 22X, 23X, 71X, 73X, 74X, 75X, and 85X. Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs. FIs pay for electromagnetic therapy services under the Medicare Physician Fee Schedule for hospitals, (CORF), (ORF), (OPT) and (SNF).

Payment methodology for independent (RHC), provider-based RHCs, free-standing (FQHC) and 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 CAHs is payment is made on a reasonable cost basis unless the CAH has elected the Optional Method and pay 115% of the MPFS amount for the HCPCS code.

In addition, the following revenues code must be used in conjunction with the HCPCS code identified:

Revenue Code	*Description*
420	*Physical Therapy*
430	*Occupational Therapy*
520	*Federal Qualified Health Center*
521	*Rural Health Center*
977, 978	*Critical Access Hospital- method II CAH professional services only*

C - Carrier Claims

Carriers pay for Electromagnetic Therapy services billed with HCPCS codes G0329 based on the MPFS. Claims for electromagnetic therapy services must be billed on the CMS 1500 or the electronic equivalent following instructions in Chapter 12 of this manual (www.cms.hhs.gov/manuals/104_claims/clm104index.asp)

Payment information for HCPCS code G0329 will be added to the July2004 update of the Medicare Physician Fee Schedule Database (MPFSD).

D - Coinsurance and Deductible

The Medicare contractor shall apply coinsurance and deductible to payments for electromagnetic therapy services except for services billed to the FI by FQHCs. For FQHCs only co-insurance applies.